Y4.V64/4: S.hrg. 99-420

S. HRG. 99-420

VETERANS' ADMINISTRATION HEALTH-CARE PROGRAMS IMPROVEMENT ACT OF 1985

COMPLETED

ORIGINAL

MF119 453

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

S. 6, Amendment 22 to S. 6, S. 875, S. 876, S. 1007, S. 1052 and Related Bills

MAY 7, 1985

Printed for the use of the Committee on Veterans' Affairs

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51-577 O

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1986

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VETERANS' ADMINISTRATION HEALTH-CARE PROGRAMS IMPROVEMENT ACT OF 1985

TUESDAY, MAY 7, 1985

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SR-418, Russell Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Chairman Frank H. Murkowski, Senators Alan Cranston, Rudy Boschwitz, Arlen Specter, Jeremiah Denton, George J. Mitchell, and John D. Rockefeller IV.

Senator CRANSTON [presiding]. The hearing will come to order.

Good morning to each and all of you.

The chairman will be here very shortly. And meanwhile, to save time, I'll make my opening statement while he's in the process of arriving.

I am pleased to welcome all of you to this hearing to consider various legislative items focusing on VA health-care issues.

We are grateful to those of you who are appearing before us today for your willingness to give us your views on the pending legislation.

Two points at the outset—my fundamental commitment to the maintenance of a strong independent VA health-care system which is capable of providing quality care that is responsive to the needs of our Nation's veterans remains unchanged. This has been and is a matter of the highest priority for me.

At the same time, I have an overriding concern that the Congress must find ways in which to reduce the enormous burgeoning Federal deficit.

It would not be realistic to expect that the VA can remain unaffected as we move ahead with Government-wide efforts to reduce the deficit. At the same time, I do not believe we can halt all efforts to maintain and improve the VA health-care system. Outdated, ineffective, or unnecessary programs can and should be eliminated; but new, needed initiatives—particularly those which respond to the changing demographics of the veteran population—can and should be given an opportunity to work.

I intend to keep this perspective in mind as we move forward with the legislation before this committee today.

As the author of S. 6, introduced on January 3, 1985, and Amendment No. 22 to that bill, submitted on April 1, I will, of course, be very interested in the witnesses' views on those measures, as well as on the other bills scheduled for this hearing.

I ask unanimous consent that S. 6 and Amendment No. 22 and my floor statements describing in detail the provisions of these two measures appear in the hearing record at an appropriate place.

Hearing no objection, that will be the order.

Because the two measures are described in detail in the floor statements, I would like, at this point, just to highlight some of the provisions.

First, section 3 of S. 6 is designed to prevent an arbitrary application of the OMB-directed Government-wide grade reduction to the VA by prohibiting the implementation of a systematic grade-reduction effort within the VA unless and until the Administrator submits to the Congress a detailed report which demonstrates that, in the personnel area concerned, the VA is overgraded in comparison to non-VA entities.

The current, wholly arbitrary reduction in the numbers of personnel in the VA in grades GS-11 through 15 is a most blatant effort by OMB, without any justification, to reduce the appropriation for the VA. This downgrading has been quite disruptive, particularly in the Department of Medicine and Surgery—both in terms of the overall reduction in the qualifications of those providing care to veterans and in terms of employee morale—and should not be allowed to go forward any further. This provision in S. 6 should help achieve that goal.

Second, section 9 of S. 6 would authorize the Administrator to carry out a pilot program in order to evaluate the effectiveness, feasibility, and desirability of various actions that would enable veterans to receive needed care in noninstitutional settings. Veterans selected to participate would be provided health services from both VA and community sources, and health-related services, such as homemaker and nutrition services, from community sources in order to help them to continue living in their communities and stay out of institutions such as hospitals and nursing homes. This program should yield important information for the VA.

Third, section 7 of S. 6 would make clear that a provision of law enacted in 1980 to promote the candor of individuals in connection with the VA's various quality-assurance programs by making the records of such activities confidential, does not preclude the release of aggregate data relating to morbidity and mortality associated with various VA health-care programs.

I continue to support the need to shield the VA's peer review process so that those who participate in such efforts will do so in a forthright manner. In my view, successful peer review activity contributes much to making the VA health-care system as good as it possibly can be, and that result is of great value to veteran patients. At the same time, however, I believe that veterans who are seeking care from the VA have a right, as consumers, to have information about the track record of various medical centers and of programs within those facilities. Only a misguided sense of paternalism would support the view, as some have suggested, that veterans should not be given morbidity and mortality statistics because such information might confuse them.

I would also like to note two provisions of S. 6 that would extend existing VA health-care authorities.

First, section 4 would extend, until the end of fiscal year 1989, the period during which veterans exposed to dioxin or other toxic substances in Vietnam or to ionizing radiation from nuclear detonations would be eligible to receive priority VA health-care services for disabilities not determined to be unrelated to their exposure.

Second, section 5 would extend, until the end of fiscal year 1988, the VA's current authority to place veterans with alcohol or drug abuse dependencies or disabilities in nonVA community-based programs for treatment or rehabilitation.

Finally, S. 6 contains three other provisions which the Senate passed last year but which our colleagues in the House were not prepared to accept at that time. These provisions would: first, expand the definition of the "Vietnam era"; second, provide that any remuneration received by a VA patient in a VA rehabilitation therapy program under section 618 of title 38 would not be counted as income for purposes of the VA Pension Program; and, third, direct the Administrator and the Secretaries of Defense and Health and Human Services to submit to the Congress a joint report on the question of U.S. Government responsibility for disabilities that possibly resulted from service in Vietnam to individuals who were present there during the Vietnam era as civilian employees of voluntary organizations that provided significant assistance to U.S. forces, such as the American Red Cross and the USO.

Again, I thank all the witnesses for your participation. I look forward to working with the chairman and other members of the committee as we develop legislation from the various bills before us.

Let me just add that former Chief Medical Director Donald Custis has submitted a written statement, which is available on the press table.

Senator Rockefeller, do you have any opening remarks?

Senator **Rockefeller**. I do, Senator Cranston, but I would simply like to submit them for the record.

Senator **Cranston**. Fine; thank you.

[The prepared statement of Hon. John D. Rockefeller IV, a U.S. Senator from the State of West Virginia, follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM THE STATE OF WEST VIRGINIA

Thank you, Mr. Chairman and Senator Cranston, for this opportunity to express my interest in the legislation that is being addressed by our Committee today. Clearly, a great deal of effort has gone into each of the bills. I commend my colleagues and the representatives of both the Veterans' Administration and the distinguished veterans organizations attending this hearing for their dedicated work in shaping and assessing the merits of different aspects of the legislation.

There are many compelling proposals in the five bills before us, which would make tangible contributions to enhancing health care for all of the Nation's veterans. I sincerely hope that this Committee and the Administration will jointly examine these bills and reach decisions aimed at adopting improvements and innovations that will serve this honorable segment of our population. I wish to emphasize that I have an open mind about each of the individual pieces of legislation, and stand ready to work with my colleagues in determining how to push for the enactment of those that are most deserving.

I would like to take a few minutes to comment on the needs of one portion of America's veterans, namely, those who served in the Vietnam war. My state, West Virginia, has about 68,000 Vietnam era veterans. Currently, when we are in the midst of a nationwide commemoration of the individuals who served in our longest war, we should pay special attention to the question of whether we are doing all we can to repay the tremendous debt we owe them.

In checking with my state, I found that our two existing readjustment centers for Vietnam veterans serve close to double the number of veterans than what is the average caseload for such centers in our country. In one center, for example, there were about 2,800 visits paid by Vietnam veterans in a 6-month period to obtain counseling, employment advice, referrals for other services, and basic companionship. The demand, in fact, is so high in the state for the two centers that our request for two more in other communities has been approved. I am grateful for this expansion but, nevertheless, interested in investigating what more should and can be done to ensure a productive and enjoyable life for this youngest generation of veterans who served our Nation in conflict.

In the five bills before us today, I see that a number of possibilities exist for building upon the effort that has been made so far to provide targeted services to Vietnam veterans. Given the tendency of these veterans in my state, for instance, to settle in more remote communities, the proposals to explore community-based alternatives for providing certain services are worthy of serious attention. In addition, the continuation of the use of halfway houses to help veterans with alcohol or drug problems appears to be critical to assisting these individuals to escape some of the unfortunate effects of combat service.

In summary, I want to make note of my concern and interest in changes in the VA health programs that would more effectively meet the needs of all veterans. And as we learn about the particular problems or challenges facing Vietnam veterans, by all means let us respond accordingly. Let us include in our recognition of the 10-year anniversary of the official end of the Vietnam war a concerted effort to assure that war's veterans of a healthy and bright future in their next 10 years and for the rest of their lives.

Senator CRANSTON. Without objection, the text of the bills S. 6, amendment No. 22 to S. 6, S. 875, S. 876, S. 1007, S. 1052; the introductory statements, and the agency reports thereon will be placed in the record at this point.

[The texts of the bills, S. 6, amendment No. 22 to S. 6, S. 875, S. 876, S. 1007, S. 1052, previously referred to, the introductory statements of the authors of the bills, and the agency reports thereon, follow:]

II

99TH CONGRESS
1ST SESSION

S. 6

To amend title 38, United States Code, to make certain improvements in Veterans' Administration health-care programs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 3, 1985

Mr. BYRD (for Mr. CRANSTON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to make certain improvements in Veterans' Administration health-care programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Administration Health-Care Amendments of 1985".

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendments to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

DEFINITION OF VIETNAM ERA

SEC. 2. Section 101(29) is amended to read as follows:

"(29) The term 'Vietnam era' means (A) the period beginning on August 5, 1964, and ending on May 7, 1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.".

VETERANS' ADMINISTRATION GRADE REDUCTION

SEC. 3. Section 210(b) is amended by adding at the end the following new paragraph:

"(3)(A)(i) The Administrator may not in any fiscal year implement a grade reduction described in division (ii) of this subparagraph unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a detailed plan for such reduction and the justification for a plan, including a determination by the Administrator, together with data supporting such determination, that, in the personnel area concerned, the Veterans' Administration has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to the number of such employees at the salary levels involved who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any such report shall be submitted not later than the beginning of a period of ninety calendar days (not including any day on which either House of Congress is not in session) prior to the implementation of any proposed grade reduction.

"(ii) A grade reduction referred to in division (i) of this subparagraph is a systematic reduction, for the purpose of reducing the average salary cost for Veterans' Administration employees performing certain functions, in the number of Veterans' Administration employees at any specific grade level who perform those functions.

"(B) Not later than the forty-fifth day after the Administrator submits a report pursuant to subparagraph (A) of this paragraph, the Comptroller General of the United States shall submit to such Committees on Veterans' Affairs a report on the Administrator's compliance with such subparagraph and shall include in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination (and of the data supporting such determination) made pursuant to such subparagraph.".

EXTENSION OF HEALTH-CARE ELIGIBILITY BASED ON EXPOSURE TO DIOXIN OR OTHER TOXIC SUBSTANCES IN VIETNAM OR TO NUCLEAR RADIATION

SEC. 4. Paragraph (3) of subsection (e) of section 610 is amended to read as follows:

"(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(5) of this section after September 30, 1989.".

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

SEC. 5. (a) Section 620A is amended—

(1) in subsection (a)(1), by striking out "pilot" both places it appears;

(2)(A) in subsection (e), by striking out "fifth" and inserting in lieu thereof "eighth"; and

(B) by striking out "pilot";

(3) in subsection (f)—

(A) by inserting "(1)" before "Not";

(B) by adding at the end the following new paragraph:

"(2) Not later than March 1, 1986, March 1, 1987, and March 1, 1988, the Administrator shall report to such committees on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by subsection (a) during fiscal year 1985, fiscal year 1986, and fiscal year 1987, respectively, and shall include in each report information for the fiscal year involved regarding the average duration of participation of veterans, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contracts entered into by the Veterans' Administration as part of the program."; and

(4) by striking out the semicolon and "pilot program" in the catchline.

(b) The item relating to such section in the table of sections at the beginning of chapter 17 is amended by striking out the semicolon and "pilot program".

PAYMENT FOR THERAPEUTIC AND REHABILITATION ACTIVITIES

SEC. 6. Section 618 is amended by adding at the end the following new subsection:

"(f) Nothwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.".

MEDICAL QUALITY-ASSURANCE RECORDS

SEC. 7. Section 3305(b) is amended by adding at the end the following new paragraph:

"(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Veterans' Administration health-care programs (including information on aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities).".

DISCIPLINARY BOARD ACTION INVOLVING CLINICAL PRIVILEGES

SEC. 8. Section 4110 is amended by adding at the end the following new subsection:

"(f) This section applies in any case in which a reduction or revocation of the clinical privileges of any person employed in a position described in paragraph (1) of section 4104 of this title is proposed by reason of a charge of inaptitude, inefficiency, or misconduct. A disciplinary board may impose a reduction or revocation of clinical privileges only (1) in a case in which, prior to the hearing under this section, such person has been provided with notice of the proposal to reduce or revoke such privileges, and (2) on the basis of deficiency in such person's clinical practice."

PILOT PROGRAM OF NON-INSTITUTIONAL TREATMENT PROGRAMS

SEC. 9. (a)(1) In order for the Administrator of Veterans' Affairs to evaluate the effectiveness, feasibility, and desirability of various actions that would enable veterans—

(A) who are eligible for hospital or nursing home care from the Veterans' Administration, and

(B) who are in need of hospital or nursing home care or of services to obviate the need for such care,

to receive needed health and health-related services in noninstitutional settings, the Administrator shall, subject to appropriations made pursuant to subsection (d), conduct a pilot program, in not less than five geographic areas, for a period of forty-eight months. In not less than three of such areas, such program shall also involve the use of a geriatric evaluation unit at a Veterans' Administration health-care facility.

(2) In the course of such program, the Administrator shall develop and provide to certain of such eligible veterans appropriate health-related services in addition to any appropriate services, such as home health or adult day health-care services, for which they may be eligible under chapter 17 of title 38, United States Code. In selecting veterans for participation in such program, the Administrator shall accord a priority to those veterans with service-connected disabilities.

(3)(A) In order to avoid duplication of services available to eligible veterans from the Veterans' Administration and other sources and to avoid fragmentation of effort under such program, the Administrator shall (i) utilize appropriate services of appropriate public and private agencies that provide health-related services, and (ii) in the case of each eligible veteran receiving services under such program, appoint a Veterans' Administration employee to serve as the case manager to coordinate the provision of services to such veteran. In order to avoid such duplication and fragmentation and to evaluate the cost-effectiveness of utilizing certain health services of an agency or agencies other than the Veterans' Administration in cases in which no Veterans' Administration facility in such a geographic area provides such services, the Administrator, in not more than two of the geographic areas at which such program is being carried out, may utilize appropriate health services of appropriate public and private agencies that provide such services.

(B) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to an entity furnishing services to veterans and subparagraph (A)(i) of this paragraph.

(4) The beginning date for such program shall be not later than the end of the fifth month after funds are appropriated pursuant to subsection (d).

(b) Not later than the end of the thirty-ninth month following the date on which the program described in subsection (a) is begun, the Administrator shall submit to the Congress a report on the results of such program during its first thirty months of operation. Such report shall contain an evaluation of the cost factors associated with providing various alternative services and combinations of service and the impact of providing such services or combinations thereof on achieving the goal of enabling eligible veterans to live in noninstitutional settings. The report shall also include any recommendations for administrative or legislative action, or both, that the Administrator considers appropriate based on the results of such program and on other pertinent information.

(c) For the purpose of this section:

(1) The term "service-connected" has the meaning given that term in paragraph (16) of section 101 of title 38, United States Code.

(2) The term "health-related services" includes, but is not limited to, homemaker, personal care, communal or at-home nutrition, and transportation assistance services.

(d)(1) Except as provided in paragraph (2), there are authorized to be appropriated for carrying out the pilot program under this section (other than for the provision of services under chapter 17 of title 38, United States Code) $10 million for fiscal year 1986 and such sums as may be necessary for each of the succeeding four fiscal years.

(2)(A) In the event that, pursuant to title III of the Congressional Budget Act of 1974, a concurrent resolution for fiscal year 1986 is in effect which sets forth total budget outlays for fiscal year 1986 in an amount which does not exceed the sum of—

(i) the total budget outlays for fiscal year 1985 set forth in such resolution (or, if not set forth therein, as estimated by the Congressional Budget Office as of the date such resolution was adopted),

(ii) the cost in budget outlays in fiscal year 1986, as estimated by the Congressional Budget Office as of the date such resolution was adopted, of such cost-of-living increases taking effect in fiscal year 1986 in entitlement programs as Congress provides for in such resolution, and

(iii) any amount by which interest on the public debt for fiscal year 1986 was estimated by the Congressional Budget Office, as of such date, to exceed the amount of such interest for fiscal year 1985,

no appropriations are authorized under paragraph (1) to be appropriated for fiscal year 1986, but there are authorized to be appropriated for carrying out the pilot program under this section (other than for the provision of services under chapter 17 of title 38, United States Code) $10 million for fiscal year 1987 and such sums as may be necessary for each of the four fiscal years succeeding fiscal year 1987.

(B) For the purpose of this paragraph, the term "entitlement programs" means programs of benefits which the United States is obligated to pay under the laws establishing such programs to persons who meet the eligibility requirements established by such laws.

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

SEC. 10. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate the question of United States Government responsibility, and alternative approaches, for providing individuals who served for a period of at least thirty days in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations, determined by the Administrator of Veterans' Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to exposure to dioxin or be the result of traumatic events), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such service.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than one hundred and eighty days after the date of the enactment of this Act, shall submit to the appropriate committees of the Congress a joint report on the question of United States Government responsibility and shall include in such report various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each) and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purpose of this section, the terms "Armed Forces" and "Vietnam era" have the meanings given such terms in section 101 (10) and (29) (as amended by section 2 of this Act), respectively, of title 38, United States Code.

[From the Congressional Record, Vol. 131, No. 5, pp. S611-S621--Senate, January 24, 1985]

S. 6—VETERANS' ADMINISTRATION HEALTH-CARE AMENDMENTS OF 1985

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Administration Health-Care Amendments of 1985, introduced on January 3. This bill has as its basic purpose the continued maintenance and improvement of the VA's ability to meet the needs of our Nation's veterans and their dependents.

As a preliminary matter, I want to note that an overriding concern for me during this Congress will be seeking out ways in which to reduce the enormous, burgeoning Federal deficit. Hence, I will be extremely reluctant to advocate any new spending by the Federal Government. Although I believe that our national obligation to those who answered the country's call to arms in its hours of need is an obligation of the highest order, I do not view all efforts relating to veterans as sacrosanct. Nor would it be realistic to expect that the VA can remain unaffected as we move ahead with Governmentwide efforts to reduce the deficit. This perspective is reflected in S. 6—which seeks to find ways to improve VA programs without incurring any significant new costs.

SUMMARY OF PROVISIONS

Mr. President, the nine substantive provisions in S. 6 would:

First, expand the definition of the Vietnam era for the purposes of title 38, United States Code, so as to include service in Vietnam at any time during the period beginning on February 28, 1961, and ending on August 4, 1964, the day before the starting date of the Vietnam era in current law.

Second, preclude the Administrator of Veterans' Affairs from implementing any systematic reduction of VA employee pay grades without first submitting to the Veterans' Affairs Committees a plan and justification for the proposed reduction, including a determination that, in the personnel area involved, the VA, in comparison to non-VA employers, has a disproportionate number of employees at the salary levels involved; and direct the Comptroller General to evaluate comment on any such VA plan, justification, and determination.

Third, extend for 3½ years, until the end of fiscal year 1989, which is 12 months after the centers for disease control plans to submit the results of the congressionally mandated epidemiological study, the period during which certain veterans—those exposed to dioxin or other toxic substances in Vietnam or to ionizing radiation from nuclear detonations—would be eligible to receive priority VA health-care services for disabilities not determined to be unrelated to such exposure.

Fourth, extend by 3 years, until the end of fiscal year 1988, the VA's current authority to place veterans with alcohol or drug abuse dependencies or disabilities in non-VA halfway houses and other community-based programs for treatment and rehabilitation, and require annual reports in 1986, 1987, and 1988 on the experience under this authority.

Fifth, provide that any remuneration received by VA patients in a rehabilitation therapy program under section 618 of title 38 would not be counted as income for the purpose of VA pension programs.

Sixth, provide that section 3305 of title 38, relating to the confidentiality of certain VA medical quality-assurance records, does not authorize or require the withholding by the VA of disclosure of statistical information regarding VA health-care programs, including aggregate morbidity and mortality rates associated with specific activities at individual VA health-care facilities.

Seventh, provide that procedures set forth in section 4110 of title 38, relating to disciplinary proceedings involving physicians and certain other VA health-care personnel employed under the special title 38 personnel system would apply in cases involving proposed reductions or revocations in the clinical privileges of such personnel.

Eighth, require the VA, in order to evaluate various actions that would enable veterans to receive needed health care in noninstitutional settings, to conduct a 48-month pilot demonstration program through which certain veterans would be helped to avoid institutional care through the provision of appropriate health and health-related services from the VA and from appropriate public private agencies.

Ninth, direct the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the Congress a joint report on the question of U.S. Government responsibility for disabilities that possibly result from service in Vietnam—such as exposure to agent orange or to particularly traumatic events—to individuals who were pesent there during the Vietnam era as employees of voluntary organizations that provided significant assistance to U.S. forces, such as the American Red Cross and the USO.

DEFINITION OF "VIETNAM ERA"

Mr. President, section 2 of S. 6 would modify the definition of "Vietnam era" for title 38 purposes to include, in the case of those who served in the Republic of Vietnam, the period beginning on February 28, 1961, the date established in Public Law 89-257 for acceptance of awards from foreign governments for service in Vietnam, and ending on May 7, 1975, the current-law ending date for the Vietnam era.

Under this provision, those who served in Vietnam during the period from February 28, 1961, to August 5, 1964, the current starting date from the Vietnam era, would be made eligible for certain benefits that are available only to veterans of specified wartime service. These benefits would include nonservice-connected pension for those who also satisfy the disability or age criteria and the income and net-worth limitations of that program; readjustment counseling; certain burial benefits; loan guaranty benefits in certain cases; certain education, on-job training, and apprenticeship benefits for educationally disadvantaged, unskilled, or unemployed veterans; and certain employment assistance, including eligibility for veterans' readjustment appointments—VRA's.

As noted above, the starting date for the Vietnam era in current law is August 5, 1964. This date coincides with the Gulf of Tonkin incident, unquestionably a watershed event in the history of U.S. involvement in Vietnam, and one which precipitated the resolution adopted by the Congress following that incident. However, there were many U.S. troops in the Republic of Vietnam prior to August 1964, and our service personnel faced combat conditions in that country well before that time.

Mr. President, establishing a starting date for a period of war such as the Vietnam conflict where there was no one, single action beginning the conflict, is admittedly an arbitrary undertaking. However, telling veterans who actually served in Vietnam prior to August 5, 1964, as we do now, that they are not Vietnam-era veterans does not seem appropriate or defensible to me. After reviewing various alternative dates, I proposed—and the Veterans' Affairs Committee and the Senate agreed last year, in taking favorable action on an identical provision in the last Congress—the date of February 28, 1961, as an appropriate starting point.

As I noted earlier, this is the date, set forth in Public Law 89-257, after which U.S. service personnel could accept awards from the Government of the Republic of Vietnam in connection with service in Vietnam. In the reports on the legislation, H.R. 3493 in the 89th Congress, that was enacted as this public law, the Committees on Armed Services in the House of Representatives and the Senate indicated that this date was selected because that was the approximate date on which American military advisers began to accompany "their Vietnamese counterparts on military operations"—House Report No. 89-239, page 2; Senate Report No. 89-800, page 2. That same date is used in other statutory contexts, including section 112 of the Internal Revenue Code, title 26, United States Code, relating to the treatment of income for tax purposes for members of Armed Forces serving in Vietnam in certain circumstances, and in section 329(a) of the Immigration and Nationality Act (INA) which appears at section 1440 of title 8, United States Code, relating to expedited naturalization based on wartime service. In addition, as noted in a letter from a Department of Defense representative to the chairman of the House Committee on the Judiciary in connection with that committee's consideration in 1966 of the INA provision as noted above, February 28, 1961, is the date selected by the Department of the Army for the award of the Combat Infantryman's Badge and the Combat Medic Badge.

As was noted in the Veterans' Affairs Committee report accompanying the legislation, S. 2514, which contained this provision in the last Congress—Senate Report No. 98–407, page 34—the committee believes that bringing the starting date of the Vietnam era for title 38 purposes into conformity with the above provisions for those who actually served in Vietnam would be an appropriate action that would make access to veterans benefits on the basis of service in Vietnam during wartime more consistent with other laws and regulations relating to such service.

I agree with this view completely and regret that our distinguished colleagues in the House were unwilling to accept the Senate-passed change. According to the Congressional Budget Office in its cost estimate on this provision during the last Congress, because there would be a "relatively low number of new (veterans made eligible for VA benefits)" there are no significant costs associated with this provision, and I have included it in this bill in order to ask our House colleagues, as well as the Senate, to give it renewed consideration.

VETERANS' ADMINISTRATION GRADE REDUCTION

Mr. President, section 3 of S. 6 is designed to address what I and many others believe is a very wrong-headed effort by the Office of Management and Budget to apply to the Veterans' Administration the Governmentwide effort to reduce the number of employees in grades GS-11 through GS-15. In order that my colleagues and others with an interest in this matter might have a better understanding of this issue, I ask unanimous consent that there be printed in the RECORD at this point an exchange of letters I had with OMB Director Stockman—my August 23, 1984, letter to Mr. Stockman and his September 19, 1984, response which enclosed a copy of an August 9, 1984, letter from him to Congressman SONNY MONTGOMERY, chairman of the House Veterans' Affairs Committee—as well as a subsequent exchange of letters between Congressman MONTGOMERY and Mr. Stockman—Congressman MONTGOMERY's October 16, 1984, letter, and Director Stockman's November 13, 1984, reply.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, August 23, 1984.
Hon. DAVID A. STOCKMAN,
Director of Management and Budget, Executive Office Building, Washington, DC.

DEAR DAVID: House Veterans' Affairs Committee Chairman Sonny Montgomery shared with me a copy of his July 23, 1984, letter to you regarding the issue of proposed reductions in the number of personnel in grades GS 11 through 15 in the Veterans' Administration's Department of Medicine and Surgery (DM&S). I agree strongly with Chairman Montgomery's views and recommendations on this issue and would appreciate receiving a copy of your response to his letter.

In addition, to the extent your response to Chairman Montgomery does not address the following points, I would appreciate receiving your responses to them:

What specific analysis, if any, has been carried out with respect to the issue of whether there is an "excess" of DM&S personnel in grades GS 11 through 15 (and, more specifically, an excess of such personnel providing direct patient-care services or services ancillary to such services)?

What opportunity has been or will be provided to VA management officials to respond to any directed grade reduction within DM&S?

Thank you for your attention to this letter.

With warm regards.

Cordially,

ALAN CRANSTON,
Ranking Minority Member.

EXECUTIVE OFFICE
OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, DC, September 19, 1984.
Hon. ALAN CRANSTON,
U.S. Senate, Washington, DC.

DEAR ALAN: This is in response to your letter of August 23, 1984, regarding the participation of the Veterans Administration (VA) in the Administration's efforts to reduce the number of government employees in grades GS-11 through 15. As you requested, we are enclosing a copy of our response to Chairman Montgomery on this issue.

This initiative arises from the Grace Commission's analysis, drawing upon data from the Office of Personnel Management (OPM), that the private sector has approximately 20 percent of white collar positions in the equivalent of the government's GS-11 to 15 range, while the government has approximately 30 percent, or a 50 percent greater distribution. Since the VA employs, primarily through the Department of Medicine and Surgery, 20 percent of the civilian workforce, we believe their employment characteristics were represented in the OPM data.

As we pointed out in the enclosed letter to Chairman Montgomery, however, all agencies will have the opportunity to seek any needed adjustment this fall. Further, agencies have been given maximum flexibility in how to meet their targets, which have been set well below normal attrition rates to avoid any adverse effect on agency employees and mission accomplishment.

Thank you for providing us your views on this important initiative.

Sincerely,

DAVID A. STOCKMAN,
Director.

AUGUST 9, 1984.
Hon. G.V. MONTGOMERY,
Chairman, Committee on Veterans' Affairs, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for your letter of July 23, 1984 expressing your views on the participation of the Veterans Administration in the Administration's effort to reduce the number of government employees in grades GS-11 through 15.

First, let me assure you that I share your concern with recruitment and retention by VA of high quality health care personnel. The priority given by the Administration to veterans health care is evident in the nearly 40 percent increase in budget authority and the addition of almost 9,000 employees for VA medical care since 1981. Given these increases, two factors lead to the conclusion that the Administration should maintain, in the VA medical care area, the effort to influence the average grade of mid-level government workers:

The VA is free to direct the application of grade level reductions among its activities so that it can maintain its own priorities within overall guidelines, and

All agencies—including the VA—will have an opportunity to seek needed adjustments this fall, as 1985 supplemental requests for pay are being formulated.

With these factors in mind, I believe that the Administration can safely continue this effort. It is one of the means toward our overall objective: to assist the VA to continue to identify the most efficient means for providing excellent medical care for our veterans in need of care.

Sincerely,

DAVID A. STOCKMAN,
Director.

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, October 16, 1984.
Mr. DAVID STOCKMAN,
Director, Office of Management and Budget, Executive Office of the President, Washington, DC.

DEAR MR. STOCKMAN: I am increasingly concerned by the attitude of the Office of Personnel Management and the Office of Management and Budget with regard to the Grace Commission's initiative which now goes under the rubric "Improved Position Management of GS/GM 11-15 Positions." On July 23, I wrote to you expressing my concern about the application of this initiative to health care personnel employed in the Veterans Administration under the authority of title 38, United States Code. I also wrote to Dr. Devine expressing similar concern. Your reply seemed to indicate that, as applied to the Veterans Administration, this initiative is a mere pretext to cutting the VA's budget for personnel compensation. More recently, I received information from the Office of Personnel Management which would indicate to me that no reduction of any sort should be applied to the Veterans Administration in any of its departments as a result of this initiative.

The justification for reductions in grades 11-15 is set forth in the background section of FPM Bulletin 312-8, which was enclosed with the reply I received from Dr. Devine. The first factor OPM cites is that 39 percent of the General Schedule full time workforce is classified in the GS 11-15 grade band. However, at the Veterans Administration this proportion is only 17.3 percent, a lower percentage than the 1959 figure for the entire government. Certainly, few large institutions, government or private, can match this figure.

The second factor cited is the average grade of the workforce. The Governmentwide average grade is noted to be 8.3, but in the VA it is only 6.38, almost two whole grades lower! Most persons will agree that some increase in average grade over the past 30 years is justifiable in light of the increasing complexity of Government functions. Therefore, the VA's average grade would seem to warrant praise as an example of how to hold the line against grade creep.

The third factor is the salaries earned in the private sector compared to those earned by government employees. I find it confusing at best when the Advisory Committee on Federal Pay reports that most Federal employees are underpaid when compared with their counterparts in the private sector, and yet the Grace Commission presents different evidence. I believe that recent remarks made about the accuracy of both reports add further confusion to this issue, so that it is not possible for anyone to say with certainty that Government employees are or are not overpaid.

Dave, there may be overgraded employees in the VA, and I tend to believe that there are too many people in grades 11-15 at the VA's Central Office, particularly in the Department of Medicine and Surgery. However, the figures cited above show that the VA compares very favorably with other Government agencies on these measures. Even if we included title 38 employees in the comparison, which the Grace Commission did not contemplate, the numbers are still favorable to the VA. This is true despite the fact that the direct provision of health care requires the VA to hire thousands of highly skilled and relatively highly paid health care professionals.

Considering all of this evidence, I would like to know whether OMB and OPM would give further thought to applying this initiative in a selective manner to those agencies where it is truly needed, and leaving agencies such as the Veterans Administration alone.

Sincerely,

O.V. (Sonny) Montgomery,
Chairman.

Executive Office
of the President,
Office of Management and Budget,
Washington, D.C. November 12, 1984.
Hon. G. V. Montgomery
Chairman, Committee on Veterans' Affairs, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Thank you for your letter of October 16, 1984, in which you express increasing concern over the application to the Veterans Administration of the Administration's effort to reduce the number of Government workers in grades GS-11 through 15. In your letter, you cite three factors as support for exempting the VA from the grade reduction effort. They are:

The percentage of VA employees in grades GS-11 through 15 is lower than the average for the Government as a whole;

The VA's average grade is lower than the Governmentwide average; and

The notion that it is impossible to say with certainty whether Government employees, as a group, are overpaid.

As you know, the first two factors result from the large number of hospital and clerical workers below GS-11 who are employed in operating the VA's hospital and benefits payment systems. Over half of VA's general schedule employees are in grades 3, 4, and 5. This obscures the fact that VA employs over 44,000 people in grades 11 through 15 (and their equivalents under Title 38), more people than the entire employment rolls of nine of the other fifteen large Federal departments and agencies.

Regarding your third factor, I believe it useful to point out that over the last four years, VA personnel compensation costs for GS and Title 38 staff have grown at a rate 28 percent faster than the general schedule pay scales. Pay for these employees (now totaling $3.7 billion) is almost 30 percent higher than it was in 1980, while the general schedule rates have increased by less than 24 percent. This matter must certainly be a cause for concern on the part of both the Executive and Legislative Branches.

You have asked in your letter whether—given the factors you cite—OMB and OPM will give further thought to exempting the VA from the GS-11 through 15 grade reduction initiative. As I noted in response to your letter of July 23, 1984, all agencies including the VA, will have an opportunity to seek needed adjustments later this fall.

I appreciate your concern that the VA be treated fairly. Please be assured that careful consideration will be given to all such requests.

Sincerely,

David A. Stockman,
Director.

Mr. CRANSTON. Mr. President, as these various letters demonstrate, the VA is being required to make reductions in the number of agency employees in grades GS-11 through GS-15 on the basis of a conclusion by private-sector volunteers on the so-called Grace Commission that, on a Governmentwide basis, there are a disproportionate number of employees in those grades and salary levels as compared to the ratio of employees at these salary levels in the private sector. Regardless of whether or not this conclusion is valid on a Governmentwide basis, these letters also demonstrate that the ratio of upper to lower GS-level employees in the VA is significantly lower than the Governmentwide ratio and that that is true both in the Department of Medicine and Surgery and the Department of Veterans' Benefits.

Mr. President, without analyzing the accuracy or meaning of the Governmentwide ratio—except to note that those findings in that regard and the meaning of those findings are very controversial—it seems clear that, in light of the VA ratio, the VA should not be required to take steps to redress an imbalance that does not exist within that agency. To apply a remedy to the VA that is defended as necessary to correct a problem that the agency is not in any way responsible for make no sense.

The only possible reason for requiring the VA to take such an action would be to reduce funding for the agency work force in an arbitrary manner. I reject such an action and believe most of my colleagues do as well, although that is, I believe, the purpose of the Office of Management and Budget in insisting that VA appropriations for health-care programs be reduced by amounts that reflect application of the grade-level reduction. In this regard, I note that OMB—according to reports I have received regarding pertinent decisions that will be reflected in the fiscal year 1986 budget submissions—has already directed such a reduction with respect to fiscal year 1985. This would apparently be achieved through offset against any supplemental request for the costs of the January 1985 cost-of-living pay increase.

Revealing clearly its motivation for this action, OMB, despite having exempted from the mandatory reduction physicians, nurses, and other VA health-care professionals employed under the DM&S title 38 health-care personnel system, has required the VA to absorb the cost savings that would be achieved if the grade reduction were applied to the title 38 personnel. Thus, there can be no doubt that OMB has a singular purpose—reducing the appropriations for DM&S—and has no great concern that its motive is so thinly disguised.

Section 3 of S. 6 is designed to prevent an arbitrary application of this Governmentwide grade reduction to the VA by prohibiting the implementation of a systematic grade-reduction effort unless and until the Administrator has first submitted at least 90 days in advance of implementation—not counting any day during which either House is not in session—a report thereon to the Committees on Veterans' Affairs. This report would be required to contain a plan for the grade reduction and, most importantly, a justification for the reduction, including the Administrator's determination, together with supporting data, that, in the personnel area concerned, the VA is overgraded in comparison to non-VA entities.

As a further check on this process, the Comptroller General would be required to submit to the two committees a report on the Administrator's compliance with these requirements and on the accuracy of the Administrator's determination and supporting data.

Mr. President, I believe this proposed process will safeguard the VA from having to implement arbitrary personnel reductions—reductions that have no justification as to VA activities—while leaving open to the agency and the Administration the opportunity to make reductions in those areas as to which it can be demonstrated that the VA is indeed overgraded. This provision, coupled with section 5010(a)(4) of title 38, United States Code, and specific direction in connection with, future appropriation action relating to the funding to support VA personnel levels should prevent in fiscal year 1986 the arbitrary appropriations reduction that OMB has imposed on DM&S this fiscal year, particularly if, as seems reasonably likely, there is no Federal employee cost-of-living pay raise in 1986.

I, along with many of colleagues in both Houses and from both parties, have worked hard over the years to ensure that the VA has sufficient, qualified staff to carry out the agency's missions. This has been particularly true in the Department of Medicine and Surgery, the Department for which the great majority of VA employees work, over 190,000 of the VA's over 223,000 full-time equivalent employees. The VA is frequently at a disadvantage competing in the relevant health-care-personnel marketplace, and the numbers of health-care workers in grades 11 through 15 and their equivalent rates under title 38 reflect the entry-level salaries necessary to meet this competition, not grade-creep of supervisory employees. It is vital to the continued ability of the VA to provide quality health care that DM&S not be forced to make unwarranted personnel changes that could seriously disrupt its ability to attract and retain needed personnel, and this provision should help to achieve that result.

EXTENSION OF HEALTH-CARE ELIGIBILITY BASED ON EXPOSURE TO DIOXIN OR OTHER TOXIC SUBSTANCES IN VIETNAM OR TO NUCLEAR RADIATION

Mr. President, section 4 of S. 6 would extend for several more years, until September 30, 1989, the provision in current law which provides certain veterans—those exposed to dioxin or other toxic substances used in herbicides or defoliants in Vietnam or to ionizing radiation from nuclear detonations—with eligibility for priority health care from the VA for the treatment of disabilities which cannot be attributed to a cause other than the exposure in question. Under current law, this authority is scheduled to terminate 1 year after the Administrator submits the first report on the epidemiological study of Vietnam veterans that was mandated by Public Law 96-151. That first report is to be submitted 24 months after the protocol for the study is approved which was on February 14, 1984. Thus, the health-care eligibility is scheduled to expire on February 14, 1987.

Mr. President, I have been deeply involved, first as chairman of the Veterans' Affairs Committee and, since 1981, as the committee's ranking minority member, in efforts to address the concerns of veterans, veterans' families, and many others about the potential health effects of veterans' exposure to dioxin and ionizing radiation. Both groups' concerns have generally fallen into three broad categories—a vital interest in receiving information about their exposure and the possible health effects of that exposure, a desire to receive health care for the treatment of conditions that may be related to their exposure, and compensation for diseases or disabilities resulting from their exposure.

As to each concern, I have developed legislative solutions, gotten them enacted, and overseen the implementation of the legislation. I am generally satisfied that, although much follow-up and oversight activity remains to be done with reference to these matters, the Congress has enacted the necessary legislation and that no additional legislation, other than relatively minor modification such as is represented by this provision in S. 6, is needed at this time. When we obtain further, reliable information regarding long-term health effects, Congress will have to reassess the adequacy of the existing legislative structure.

With specific reference to the issue of health care for disabilities that may be related to exposure to these hazards, I am proud to have authored in the Senate Public Law 97-72 which was enacted in 1981 to give both groups of veterans interim, special priority and eligibility for VA health care. As I noted during final Senate consideration of that legislation, I view the enactment of this health-care eligibility as providing important, temporary relief while the Government continues to gather information necessary to make final decision about establishing service-connected status for various disabilities.

I am proposing to extend this authority because the major studies designed to yield the necessary information—the epidemiological study of Vietnam veterans mandated by Public Law 96-151 and expanded by Public Law 97-72 which is being carried out by the Centers for Disease Control—CDC—and the scientific study of the health status of veterans exposed to radiation mandated by Public Law 98-160—will not be sufficiently advanced by 1987 to permit final decisions to be made.

Although picking any cut-off date for this authority—that is, a date by which the Congress should be able to address the question of access to health care on a more permanent basis—cannot be a very precise process, I am proposing September 30, 1989, on the basis of CDC's plans to report on the agent orange study in September 1988. If that target date is met, the Congress should then have sufficient time to evaluate the results of that study and other pertinent information and decide as to appropriate further action with regard to dioxin exposure prior to the 1989 expiration date.

In this regard, so that my colleagues and others might be brought up to date on these studies, I ask unanimous consent that the most recent report from the Office of Technology Assessment—the agency which has a statutory responsibility for monitoring these studies—on the status of the studies, as set forth in a December 12, 1984, letter to me from OTA Director John Gibbons, be printed in the RECORD at this point.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONGRESS OF THE UNITED STATES,
OFFICE OF TECHNOLOGY ASSESSMENT,
Washington, DC, December 12, 1984.

Hon. ALAN CRANSTON,
Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate, Washington, DC.

DEAR ALAN: Public Law 98-160 mandates that I report to the appropriate Committees about progress in studies to determine possible long-term health effects among veterans exposed to nuclear radiation. This letter is my second report. As I did in the first report (May 24, 1984), I will also use this letter to inform you of OTA's activities related to Agent Orange as mandated by Public Laws 96-151 and 97-72.

ATOMIC VETERANS

In May, I reported that I was expecting to consult with the Administrator of Veterans Affairs about the feasibility of a Veterans Administration (VA) plan for the study of veterans exposed to radiation from weapons testing. At that time, I had been informed that the newly formed Committee on Interagency Radiation Research and Policy Coordination, which is chaired by the Office of Science and Technology Policy, was reviewing the study plan. My understanding was that the study plan and the committee's review and comments would be returned to the VA in late June or early July.

Unfortunately, events have not followed that schedule. The plan and the committee's review did not reach the VA until mid-November. OTA staff, in conversations with VA staff, have been told that the Department of Medicine and Surgery at VA is now examining the study plan and the review preparatory to making a recommendation to the Administrator. I expect and hope that the Administrator will be contacting me in the next two or three weeks about OTA's consulting with him.

As you know, veterans who claim damage from radiation exposure are prevented from suing the Federal government by the Feres Doctrine, a 1950 Supreme Court decision, that prohibits suits against the government for injuries related to military service. Furthermore, a recently enacted law prevents veterans from suing government contractors for damages from radiation. I believe that those two restrictions eliminate any opportunity for a veteran who believes he was harmed by radiation to obtain relief through the courts. If my interpretation is correct, veterans can only turn to the VA for compensation, and, according to news reports, few veterans have been compensated. While the decisions not to compensate may be justified on scientific grounds, there still remains a perception on the part of some people that veterans may have been harmed by the radiation exposure. The proposed VA study takes on added importance because, rightly or wrongly, it can be viewed as the last chance for veterans to obtain evidence to support their claims of injury.

I am still unable to predict how much time and effort OTA will have to invest in its review of the VA study plan to enable me to consult with the Administrator. However, if OTA's review will take substantially longer than 30 days after we receive the plan, I will inform the Committees.

Agent Orange

OTA's mandate to monitor the conduct of epidemiologic studies of Vietnam veterans has led to a broad range of activities including review and comment on other Agent Orange and Vietnam experience studies. Virtually all the studies are being conducted directly by or on contract to the VA or Centers for Disease Control (CDC) and employ similar methods for estimating exposures and measuring outcomes. Those common elements make the congressional requests for OTA's views logical extensions of the OTA mandate. In this letter, I will first provide an update on developments in the Congressionally mandated CDC studies and then discuss two OTA activities not directly covered by the mandate.

The studies have moved steadily ahead since May. One important personnel change has taken place. Dr. Peter Layde, who has been working on the studies since CDC began them, has assumed responsibility as Director for Agent Orange Projects. Dr. J. David Erickson, who began as project director, requested that he be allowed to return to his work in the epidemiology of birth defects, his specialty.

We have received two quarterly reports from CDC, one in July, the second in October. You will recall that CDC's studies of the health of Vietnam veterans include three components: the Agent Orange study, the Vietnam Experience study, and a study of Selected Cancers that have been associated with exposure to dioxin. The reports make it clear that the three studies are, in general, on schedule. Several contracts have been awarded and others are in review. The Research Triangle Institute (Research Triangle Park, NC) has been awarded the contract to contact and conduct telephone interviews of the 30,000 participants in the Agent Orange and Vietnam Experience studies. Several bids for the physical examination contract were received, and CDC expects to make an award for the conduct of 10,000 examinations in February 1985.

Six cancer registries (at Emory University, Yale University, University of Miami, University of California at Berkeley, University of Kansas, and Iowa State University) are under contract to locate and interview individuals ("cases") who have the cancers included in the selected cancer study. Individuals who are to be "controls" are to be identified by WESTAT, Inc. (Rockville, MD), and interviewed by personnel from the cancer registries. Proposals for contracts to provide pathological review of the cancers in the study are being reviewed by CDC.

CDC expressed concern that requirements of the Office of Management and Budget (OMB) might eventually cause delays. OMB is requiring that results of pilot studies be submitted to the Agent Orange Working Group (AOWG) for review before proceeding with the full study. This applies to the Agent Orange and Vietnam Experience studies. The Selected Cancers Study was approved unconditionally.

In a third and separate report, CDC described very encouraging results from the Vietnam Experience pilot study. The pilot study was designed to evaluate (1) the success of locating and securing participation of veterans in the study, and (2) the quality of the questionnaire to be used in the telephone interviews. The overall location/participation rate of 83 percent is substantially higher than CDC's goal of 70 percent for the pilot study. The participation rate for those contacted was 97 percent, an extremely high figure for this type of study.

The questionnaire was administered through a computer assisted telephone interview (CATI) system by the Research Triangle Institute, under contract to CDC. The interviewers and the CDC researchers used the experience of interviewing 300 Vietnam-era veterans to make minor adjustments to the questionnaire itself, generally to improve the flow and to increase the understandability of the questions.

BEST COPY AVAILABLE

The process of reviewing military records and identifying those individuals who meet the study criteria ("qualifying" veterans) for the Vietnam Experience study is ahead of schedule. This work is carried out by cooperative efforts of the U.S. Army and Joint Services Environmental Support Group, the National Personnel Records Center, and several other Federal agencies, in concert with CDC.

CDC has been considering the feasibility of a study of female Vietnam veterans. It considers such a study to be feasible, and has broadly outlined a research protocol. OTA has not as yet formally addressed this issue, but, as part of the mandate to review and approve protocols for the study of Vietnam veterans, will do so when a reviewable protocol becomes available.

Communication between CDC and OTA, which we felt was not as good as it should have been, has improved, and appears to be on firm footing. Dr. Layde has met with OTA staff, and we are now confident that the communications lines will function to benefit both CDC and the Congress. In general, our relationship with CDC has been one of mutual cooperation, and we expect that to continue.

OTA's Review of the CDC Birth Defects Study.—This activity stems not from the Congressional mandate, but from requests from both Houses. A report of the study, "Vietnam Veterans' Risk of Fathering Babies with Birth Defects," was published in the Journal of the American Medical Association, and the full study was published by CDC. OTA received a letter from Senator Cranston (August 15, 1984) asking that we review the study, and subsequent letters from Representative Edgar (August 17, 1984) and from the Chairman and Ranking Minority Members of the House Committee on Veterans' Affairs (Representatives Montgomery and Hammerschmidt) on August 30, 1984 requesting copies of our review. We also received a request from the House Veterans' Affairs Committee Subcommittee on Hospitals and Health Care to testify at a hearing on this subject on October 3, 1984.

OTA's testimony raised serious questions about the validity of the findings concerning Agent Orange. The main conclusions of the study, that there was no detectable increase in major birth defects associated with service in Vietnam, are not affected by OTA's analysis. However, OTA's analysis casts doubt on the CDC findings that two specific birth defects (spina bifida and cleft lip with or without cleft palate) and a third category containing an aggregate of cancers were associated with increasing likelihood of Agent Orange exposure as estimated by an "Agent Orange Exposure Opportunity Index."

OTA's reservations about the utility of the "exposure opportunity index" extend well beyond the birth defects study because several ongoing or planned studies will be using similar indices. The upshot of OTA's testimony is that the methods used to derive the index and the resultant estimates of likelihood of exposure are now under review by the AOWG Science Panel. OTA is participating in that review effort. It is our understanding that the Science Panel and the U.S. Army and Joint Services Environmental Support Group, the unit that processes records and gathers information to be fed into the index, will work toward agreement on a valid index before it is used in any more studies.

OTA Involvement in the VA "Vietnam Experience Twin Study" (VETS).—A study under consideration at the VA is designed to examine the effects of Vietnam service and Agent Orange exposure on identical twins. Representatives Montgomery and Hammerschmidt asked OTA to review the protocol for this study and to make a recommendation about whether the study is "scientifically meritorious" and whether the study plan "presents a sound and efficient method of achieving that purpose" (letter of November 7, 1984). The study has been in planning for about two years and has been something of a hot potato at the VA. The report of a group of consultants recently assembled by the Research and Development division of the VA Department of Medicine and Surgery recommends that the study not be executed. Others at the VA and elsewhere in the Executive Branch are keenly in favor of doing the study. Whether the study ultimately goes ahead or not may well hinge on the OTA review. Our review will be assisted by the standing OTA Agent Orange Advisory Panel supplemented with outside experts who have not already been party to one of the previous reviews.

Currently OTA plans to hold an Agent Orange Advisory Panel meeting to discuss VETS and progress on the Vietnam Experience and Agent Orange studies sometime in February 1985. In my May letter, I predicted that this meeting would be held in late summer of 1984, but we have postponed it until CDC is ready to present results of its pilot studies.

I would appreciate any comments you may have about OTA's activities and plans. If you wish additional information, please call me at 224-3695 or Dr. Michael Gough or Ms. Hellen Gelband at 226-2070.

Sincerely,

JOHN H. GIBBONS.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

Mr. CRANSTON. Mr. President, section 5 of S. 6 would amend section 620A of title 38, which provides authority pursuant to which the VA may contract with various community facilities to provide care and treatment to veterans suffering from alcohol or drug dependence or abuse disabilities, to change that authority from a pilot program and extend it for 3 years, through the end of fiscal year 1988. This provision is similar to one passed by the Senate last year but which our colleagues in the House were unwilling to accept at that time.

The pilot program authority, which I authored, was enacted in 1979 in Public Law 96-22 and is scheduled to expire on September 30, 1985. Pursuant to section 620A(f) of title 38, the Administrator was required to submit by March 31, 1984, a report on the operations of the pilot program through September 30, 1983.

This VA report on the initial experience under the program, which was finally submitted in early May last year, was generally quite positive about the impact of the program through 1983. However, because of concerns of some members of the committee that more needed to be heard about the program before the authority was made permanent—as I had originally proposed last year in section 8 of S. 2269—the committee last year authorized only a 2-year extension. As I noted earlier, the Senate passed such a measure, but it was not included in the final compromise legislation developed with the House.

On the basis of all of the evidence that I have reviewed—including the VA report as well as reactions from veterans who have been placed in halfway houses and other community-based facilities, VA employees who work with veterans with drug or alcohol abuse dependencies, and individuals associated with various community-based drug and alcohol treatment programs—I remain convinced that the pilot program has been quite successful in enabling significant numbers of veterans to receive appropriate and helpful assistance. I intend to work hard for the adoption of this extension.

PAYMENT FOR THERAPEUTIC AND REHABILITATION ACTIVITIES

Mr. President, under section 618 of title 38, the VA operates, in the Department of Medicine and Surgery, therapeutic and rehabilitation programs under which participants—VA patients, either inpatients, residents in domiciliary facilities, or outpatients, selected for such programs—perform services for which they receive a small payment. These programs are known commonly as incentive therapy—IT—and compensated work therapy—CWT—programs. The IT programs involve patients being assigned duties within the treating VA medical center whereas the CWT programs involve work under VA contracts with private industry. Both programs are designed to promote self-sufficiency in the participating patients.

In 1983, the VA's Inspector General conducted an audit that indicated that many veteran-patients participating in these programs were also in receipt of VA pension and were not reporting as income for pension purposes the payments they received from their participation in IT or CWT programs. In response to this report, the VA's Department of Medicine and Surgery instituted a program of income verification pursuant to which VA medical facilities, as of approximately January 1, 1984, began to inform appropriate regional offices of the Department of Veterans' Benefits of the amounts paid to veteran patient participants in these programs. For many of these veterans who are in receipt of pensions under the VA's non-service-connected disability pension program, this change in how IT/CWT payments are counted has the result of reducing benefits by an amount equal to the amount received by the veteran under incentive therapy. Thus, for every dollar a patient receives under incentive therapy, his or her pension is reduced by $1 and he or she is no better off financially as the result of IT/CWT participation. This change in how these funds are counted has already had the entirely predictable result of discouraging participation in these programs among those in receipt of VA pension. The General Accounting Office is investigating this matter and should have some preliminary findings by April 1, 1985.

Mr. President, I have received complaints from staff of IT and CWT programs, other VA employees, veteran participants in these programs, veterans' service organizations, and others about the adverse impact on these programs that counting these payments as income was having. To remedy this unfortunate situation, I proposed legislation last year in amendment No. 2850 to specify that payments under these programs not be counted as income for purposes of VA pension.

As is noted in the committee report accompanying VA health-care legislation last year, S. 2514—Senate Report No. 98-487, pp. 67-68—this proposal received wide support during the committee's April 11 hearing. In light of the record before the committee on this issue, the Committee determined that it was important to take steps with respect to the relationship between payments earned by participants in these programs and their eligibility for VA pension.

However, instead of the permanent solution I had proposed, the committee agreed to a provision requiring the VA to conduct a 3-year demonstration project, ending December 31, 1987, during which payments received by participants in connection with their participation in IT and CWT programs would not be counted in determining annual income for VA pension purposes. Under the committee bill last year, the administrator would have been required to submit a report by February 1, 1987, on the experience under this proposed demonstration project during fiscal years 1985 and 1986.

This short-term action was proposed because of a lack of comprehensive information on, first the extent to which participants in the program are in receipt of VA pension; the extent to which such participants are adversely affected by counting IT/CWT payments in determining annual income for pension purposes; and, the extent to which veterans, because of participation in the program, have gained employment and are no longer in receipt of pension.

Although I believed there was a sufficient basis for more comprehensive action, I supported this demonstration program. Unfortunately, our colleagues in the House were unwilling to accept even the demonstration project.

Because of my very strong, personal interest in and support for the IT and CWT programs, and my belief that offsetting any payments received in these programs against pension payments severely restricts the value of these programs, I have again introduced a provision, section 6 of S. 6, to provide for a permanent exclusion of therapy payments in the computing of income for purposes of VA pension and will work hard for its enactment.

MEDICAL QUALITY ASSURANCE RECORDS

Mr. President, section 3305 of title 38 makes certain VA records confidential and, except in certain specified situations, prohibits any disclosure of these records outside of the VA. The records which are sought to be protected by this provision of law, which was enacted in 1980, are those created by the VA through the agency's medical quality-assurance program.

Under the VA's medical quality-assurance program, known as the Health Services Review Organization—HSRO—Program, VA medical professionals review the health-care activities in a facility to determine what deficiencies exist in such care so as to recommend corrective action. The program is divided into two main components: An external review process—the Systematic External Review Program—SERP—involving teams composed of VA medical and dental professionals from outside a particular VA facility who conduct a comprehensive review of all facets of the facility's operation; and the Systematic Internal Review Program—SIR—a program of ongoing reviews in each VA facility conducted by designated committees made up of physicians and other health professionals from the facility's own staff. Each component of this quality assurance program produces various documents which contain information identifying individual VA patients or employees, such as those conducting the reviews, citing and describing any inappropriate medical practices and deficiencies discovered in the provision of health care, and making recommendations for corrective actions.

Because these quality-assurance efforts depend to a significant degree on the willingness of the VA personnel conducting the reviews to be completely candid in their comments and because of concerns that this vital degree of candor could be lost if the participants could not be assured that their remarks and evaluations incorporated in SERP and SIR reports would be kept confidential, the Congress acted to place stringent limitations on the disclosure of these documents.

However, there have been a number of reports since 1981 of situations in which various VA facilities have relied on section 3305 to refuse disclosure of information and records that did not appear to warrant the confidentiality accorded by that section. In a recent example of such misplaced reliance on section 3305, the VA resisted disclosing to a journalist with the Fort Lauderdale News-Sun Sentinel aggregate information regarding mortality data associated with the agency's cardiac surgery program, both at a Florida VA medical center and nationwide. In my view, such a withholding of information about Government programs is not good public policy.

In order to ensure that the intent of Congress in enacting section 3305 is clear—namely, that medical quality-assurance records should be kept confidential but only to the extent necessary to promote the candor of individuals involved in the quality-assurance process—and to specify generally that withholding aggregate data relating to morbidity and mortality associated with various VA programs is not necessary to achieve this purpose, I am proposing an amendment to section 3305. This amendment, set forth in section 7 of S. 6, will make it clear that such aggregate information is not made or considered confidential as medical quality-assurance records. Thus, unless some other basis for nondisclosure exists, such information would be available for disclosure.

DISCIPLINARY BOARD ACTION INVOLVING CLINICAL PRIVILEGES

Mr. President, section 4110 of title 38 sets forth, in broad outline, the procedures that are to be followed in cases involving charges of "inaptitude, inefficiency, or misconduct" brought against VA health-care personnel employed under the VA Department of Medicine and Surgery's title 38 personnel system—namely, physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expended-function dental auxiliaries. Together with the implementing guidelines which are set forth in a VA personnel manual, this provision provides due process protections to these health-care personnel involved in disciplinary actions.

Recently, in connection with VA actions against a physician at a VA health-care facility in California, I came to realize that it was the agency's view that the provisions of 4110 do not apply in a case involving a reduction or revocation of clinical privileges—the types of health-care services that the individual is authorized to perform as a VA employee at a particular VA facility. It appears that the VA's view in this regard is premised on the point of view that such an action is not a true adverse action worthy of the due process protections—such as the right to confront witnesses and the right to a decision on the record—that apply in proceedings under section 4110 and that, even if, for example, an individual physician suffers a reduction or loss of clinical privileges, he or she would still be employed and would thus not have suffered a significant loss.

I believe that clinical privileges are a very fundamental component of a physician's or other health-care professional's employment with the VA. Although it might well be true that an individual could still be employed by the VA following a reduction or revocation of clinical privileges, such a loss would have a very serious impact on the individual's professional reputation and career opportunities. Thus, I am proposing, in section 8 of S. 6, to amend section 4110 so as to make the provisions of that section expressly applicable in any case in which a reduction or revocation of clinical privileges is proposed on the basis of a deficiency in the individual's clinical practice. Also, because I believe that clinical privileges are so directly related to a physician's or other professional's clinical competence and that they should be at risk of loss or reduction only in a situation in which he or she has been put on notice and, if his or her conduct as a professional is the basis for the action, notified of the particular charges involved, this provision in S. 6 would limit the power of a disciplinary board to reduce or remove privileges by requiring that before this could be done appropriate notice must first be provided to the employee and the board's finding must be based on a finding of a deficiency in the individual's clinical practice.

PILOT PROGRAM OF NONINSTITUTIONAL TREATMENT PROGRAMS

Mr. President, as most of my colleagues understand and appreciate, because of the very large number of World War II veterans whose average age is nearing 65, the VA is involved in issues related to aging to a much greater degree and on a more urgent basis than most other departments and agencies of the Federal Government. Concerns about the graying of America that still have a somewhat theoretical concern to many are immediate and quite real to the VA. The number of veterans 65 and over will increase from approximately 4 million at present to 7 million by 1990 and 9 million by 2000. At present, less than 40 percent of the males 65 and over are veterans; by the year 2000, over 62 percent of this population will be veterans. No matter how some issues are resolved that are likely to be debated in the coming years regarding the VA and eligibility for VA services, it is abundantly clear that the VA will be providing assistance to a very significant number of older veterans in the years ahead.

Section 9 of S. 6 is part of a series of efforts in recent years that have attempted to address this issue and to help prepare the VA to meet the challenge. This provision would require the Administrator, in order to evaluate the effectiveness, feasibility, and desirability of various actions that would enable veterans to receive needed care in noninstitutional settings, to carry out a pilot program in five geographic regions, for a period of 48 months, during which veterans participating in this program would receive coordinated services, both health care and health-related services, from the VA and, under certain circumstances, from appropriate public and private agencies that provide such services. Under this pilot program, veterans would be selected to participate on the basis of their eligibility for hospital or nursing home care and their need for such care or for ambulatory care to obviate the need for such institutional care. These veterans would be provided health and health-related services, such as homemaker and nutrition services, in order to help them remain living in their communities and out of institutions, such as hospitals or nursing home facilities. Such a result has a double benefit: Veterans will be receiving needed care in a more humane environment which is more conducive to their regaining their health while, at the same time, the cost of their care will be reduced. Finally, in order to ensure that the desired level of coordination exists between the VA and non-VA service providers, each veteran participating in the pilot program would have a case manager who would be charged with responsibility for coordinating the veterans' access to the appropriate mix of needed services.

Mr. President, I believe that this pilot program could provide important information for the VA in a variety of important respects. First, the emphasis on providing noninstitutional care should promote greater understanding about the process of placing veterans in need of care at the lowest, most appropriate level of care available and of the benefits of such actions—both to the veteran and in terms of cost, as noted earlier. This approach will become increasingly important in the years ahead as the potential demand from older veterans for care could easily overwhelm the agency's existing bed capacity. In this regard, I note that under the pilot-program provision in the bill, in at least three of the geographic regions involved in the pilot program, a geriatric evaluation unit (GEU) at a VA health-care facility would have to be involved. I have been very encouraged by the early reports on the success of GEU's within the VA—most recently, the very positive report in the December 27, 1984, issue of the New England Journal of Medicine on the results of a research project at the GEU at the Sepulveda VA Medical Center—and I look forward to a further evaluation of these units as part of this pilot project.

A second area in which I believe the pilot project can yield important new learning involves VA-community interaction and cooperation. As I noted earlier, under the pilot program, veterans would receive both health and health-related services. It is my anticipation that the latter services—such as homemaker, personal care, communal or at-home nutrition, and transportation assistance services—would come almost exclusively from public and private agencies already providing such services in the various communities in which the program is carried out. The VA-community interaction necessary to make arrangements for VA patients to receive these services and to coordinate the provision of services with VA health-care services for the veterans involved has the potential of providing significant benefit to both parties in such an arrangement.

In this regard, I note the testimony of the VA's then-Chief Medical Director, Dr. Donald Custis, before our committee in June 1982, when he addressed this issue of VA-community cooperation and how improving such cooperation might better enable the VA to meet the needs of older veterans. In remarks that appear on pages 24-25 of the committee's June 30, 1982, oversight hearing on Veterans' Administration's health-care programs and policies affecting needs of aging veterans, he stated:

> I should like to put forward what I believe is a new approach to VA-community interaction. It is based on the evident fact that all the statistics I have cited to you, confined as they are to veterans as actual and potential patients in our system, may seem to bypass the fact that America is "graying." The issue of an aging population and what means exist or must be created to deal with it creates a set of problems for society as a whole.
>
> It seems to me that we must begin to work with communities all over this country in a variety of ways that recognize that we are a part of the problem (albeit a large part, with an estimate that 60% of all males over 65 in 1990 will be veterans). It should follow then, that we are only a part of the solution. I think we should, on a local basis, begin to participate in the creation of structures to deal with overall problems of an aging population, some of whom are veterans, so that we can work together with the communities to get the best "bang" for both their "bucks" and ours.
>
> We have recently launched, within the Department of Medicine and Surgery, a Medical District Initiated Program Planning (MEDIPP) process which will increasingly rely on planning that comes up to the center from the grass roots. Through this and other means, we want to encourage the growth of such considerations on the local level, the initiation of experiments along these lines and the search for valid interlocutors in the communities where we are located.
>
> It may be, if we can succeed in starting and nurturing the growth of such VA-community interactive structure, that both the VA facilities and the communities in which they are located can accomplish more with existing and additional resources than each of us is now doing or can anticipate doing alone.

In regard to this idea, let me note that I am proposing some experimentation in the area of a new Federalism, one which makes use of our resources and knowledge, the resources and knowledge of other Federal agencies, and the states and communities.

The agency itself, in a report issued last year—"Caring for the Older Veteran"—addressed the same point in setting forth the following as one of five goals for DM&S in meeting the needs of older veterans:

> NATIONAL AND COMMUNITY COORDINATION STRATEGIES
>
> Goal: To exert maximum efforts to coordinate and integrate VA programs for the aging veteran with similar programs in the community at large in a fashion which will benefit both the VA and the community.

Mr. President, it is just such an interaction of Federal, State, and local resources as Dr. Custis described and the VA advocated that I am proposing the VA carry out.

Two recent activities involving the VA and non-VA organizations and individuals concerned abut VA-community cooperation and interaction provide strong support for increased action in this area. The first was a collaborative project between the VA and the Division of Health Policy Research and Education at Harvard University which was designed to explore improved integration of VA and community resources for caring for the elderly. This project featured a conference held in the fall of 1983 and the recent publication of a book, entitled "Older Veterans: Linking VA and Community Resources," embodying the results, of that conference. The second activity was a joint conference in September 1984 sponsored by the VA and the American Health Planning Association entitled "The Complex Cube of Long Term Care." Both activities demonstrate the VA's vital interest in the question of how the agency, in cooperation with outside entities, can best meet the needs of the increasing population of older veterans and also show the strong interest in such cooperation on the part of many non-VA entities. Certainly it is clear that such interaction is needed and needed now, both for the sake of the VA and the Nation as a whole. As is noted in the preface to "Older Veteran: Linking VA and Community Resources":

> The nation's demographic changes over the next half century will be compressed into two decades for the Veterans' Administration. The response of the VA to this challenge will provide models for caring for the growing population of elders, veteran and non-veteran as well.

I believe that the proposed pilot project will help further that VA effort as well as contribute to the Nation's knowledge about caring for its elderly citizens.

As a final point regarding the pilot program, I note expressly the funding provision that I am proposing for it. As I noted at the outset of my remarks, I am strongly committed to seeking ways in which to bring the enormous Federal deficit under control and, because of this, will be extremely reluctant to advocate any new spending by the Federal Government. Although I do not anticipate that this pilot program will incur great costs—I am proposing an authorization of $10 million for the first fiscal year—it would represent a new expenditure and I do not wish to submit any proposal that would be inconsistent with efforts to develop a fiscal year 1986 budget premised on a Government-wide freeze concept. For this reason, I have included a provision relating to the authorization of appropriations for the pilot program specifying that, if the Congress adopts a first concurrent resolution on the budget for fiscal year 1986 which is based on a comprehensive freeze in Government spending or which incorporates a fiscal 1986 spending level no greater than the total of fiscal year 1985 outlays plus the costs of any cost-of-living increases provided for in entitlement programs and the amount by which interest on the public debt in fiscal year 1986 exceeds fiscal year 1985 interest, then no appropriations would be authorized for the pilot program in fiscal year 1986. Thus, if there is congressional agreement in support of such a freeze in fiscal year 1986, this pilot program would not begin before fiscal year 1987; if, on the other hand, no such agreement is reached, appropriations for the program would be authorized for fiscal year 1986. I included a similar provision in S. 4, the proposed "Child-Care Assistance Act of 1985," legislation also introduced on January 3, to improve child-care assistance efforts.

In future years, it would be my intention to seek reductions in spending in other areas—not necessarily in veterans' programs—to offset any new funds appropriated for this pilot program. This approach would allow us to continue to address pressing areas of concern in a fiscally prudent manner. Costly, outdated, ineffective, or unnecessary programs should be eliminated or trimmed back so that new, needed initiatives can be funded.

Given the changing demographics and the growing demand for care from older veterans and the VA's likely inability to meet that demand on its own, this pilot program is certainly a new initiative that should be pursued. We cannot halt all progress in attempting to address these types of issues, but we can and must proceed in a fiscally prudent manner. This obviously means making decisions about existing programs so that there will be room in the overall Federal budget for new initiatives. And these decisions need not be confined just to the domestic side of the Federal budget. Certainly, some of the tradeoffs should be from pruning back some unnecessary spending in the defense budget so that we can meet our obligations to those who served in the past.

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

Mr. President, last year, in response to concerns from a number of non-Federal civilians who were present in Vietnam during the Vietnam era with voluntary organizations—principally the Red Cross and the USO—about the effects of their presence there on their health and the Federal Government response to their concerns, I introduced and the Senate passed legislation which included a provision mandating a joint report from the VA, Department of Defense, and Department of Health and Human Services on this issue. Under the provision passed by the Senate, section 12 of H.R. 5618, the required report would have contained an evaluation of the question of U.S. Government responsibility—and alternative approaches for providing Federal and other benefits, services, and assistance to these civilians—for disabilities that possibly result from certain aspects of their presence in Vietnam, such as exposure to agent orange or to particularly traumatic events.

Unfortunately, our distinguished colleagues in the House would not accept this provision last year and, thus, it was not included in the final compromise legislation.

I have again introduced such a provision, as section 10 of S. 6. As I have noted in the past, for those who served in Vietnam with the military, there can be no question about the Federal Government's responsibility to address concerns they raise regarding adverse health effects of service in Vietnam—whether as a result of exposure to herbicides such as agent orange or through other experiences there. In the case of these former service members, it is also very clear that it is the VA which bears the majority of this responsibility. Thus, our committee has engaged in considerable activity in seeking responsive Federal Government action to deal with concerns regarding the long-term health effects of Vietnam service, with special attention to the question of the long-term health effects of herbicides, such as agent orange, which were sprayed in Vietnam by the U.S. military as a means of depriving the enemy of cover and food.

In view of the contribution that the individuals who worked in voluntary organizations in Vietnam provided to their country and their concerns about the long-term health effects of their work in Vietnam that may be related to actions of the Federal Government, I continue to believe strongly that the Federal Government has the responsibility, at least, to evaluate these concerns and consider possible appropriate alternatives—Federal and non-Federal—for addressing them. It is for this reason that I am again introducing this report provision.

CONCLUSION

Mr. President, as I noted at the outset, the diverse provisions of this bill have as a general unifying purpose bringing about the continued improvement of the VA's ability to meet the needs of our Nation's veterans and their dependents. I look forward to working on this measure with the new committee chairman, the distinguished Senator from Alaska [Mr. MURKOWSKI], and other members of the committee, the VA, the veterans' service organizations, and others interested in legislation affecting veterans.

I want to take this opportunity to note the transition in the committee chairmanship. Since 1981, the committee has been guided by the firm hand of my very good friend from Wyoming [Mr. SIMPSON]. Upon AL's election as majority whip, he had to relinquish the committee chairmanship. I will miss him greatly in that role. His strong, personal, very sincere interest in matters coming before the committee and his effective work as chairman have been of genuine benefit to our Nation's veterans. I am sure he will continue to play a very active role on the committee, and I look forward to continuing to work with him both on the committee and in our mutual roles as whip for our parties.

At the same time, I wish publicly to extend hearty congratulations to the new chairman. Immediately upon his arrival in the Senate in 1981, FRANK MURKOWSKI was assigned to the Veterans' Affairs Committee. His first 4 years on the committee have provided him with an impressive foundation of experience on which to build as chairman, and I stand ready to work closely with him as he assumes this important job.

Mr. President, I ask unanimous consent that the text of S. 6 be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

* * * * *

AMENDMENT NO. 22 **Pr.** ______ **Calendar No.** ______

Purpose: To make a technical amendment to conform subsection (g)(1)(B) of section 612A of title 38, United States Code, relating to the continuing availability of Veterans' Administration readjustment counseling services for Vietnam-era veterans, to the amendment of subsection (a) of such section made by section 101(a) of the Veterans' Health Care Amendments of 1983.

IN THE SENATE OF THE UNITED STATES— 99th Cong. 1st Sess.

S. 6

H.R. ______ **(or Treaty** ______ **)**
SHORT TITLE

(title) To amend title 38, United States Code, to make certain improvements in Veterans' Administration health-care programs, and for other purposes.

AMENDMENT NO. 22

( ) Referred to th
and ordered to
( ) Ordered to lie

By CRANSTON

Bill/Res. No. S. 6

INTENDED to be proposed by M

GPO : 1984 - 39-831

Viz: At the end of the bill, add the following new section:

Technical, Conforming Amendment Relating to the Continuing Availability of Readjustment Counseling

SEC. 11. Section 612A(g)(1)(B) is amended by striking out "who requested such counseling before such date" and inserting in lieu thereof "who request such counseling".

[From the Congressional Record, Vol. 131, No. 39, p. S3796--Senate, April 1, 1985]

IMPROVEMENT IN VETERANS HEALTH CARE PROGRAMS

CRANSTON AMENDMENT NO. 22

(Ordered referred to the Committee on Veterans' Affairs.)

Mr. CRANSTON submitted an amendment intended to be proposed by him to the bill (S. 6) to amend title 38, United States Code, to make certain improvements in Veterans' Administration health-care programs, and for other purposes; as follows:

At the end of the bill, add the following new section:

TECHNICAL, CONFORMING AMENDMENT RELATING TO THE CONTINUING AVAILABILITY OF READJUSTMENT COUNSELING

SEC. 11. Section 612A(g)(1)(B) is amended by striking out "who requested such counseling before such date" and inserting in lieu thereof "who request such counseling".

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am today submitting for printing amendment No. 22, an amendment to S. 6, the proposed Veterans' Administration Health-Care Amendments of 1985. S. 6 is presently pending in the Veterans' Affairs Committee.

Mr. President, this amendment is a technical, conforming amendment to section 612A(g)(1)(B) of title 38, United States Code, relating to the continuing eligibility of Veterans' Administration readjustment counseling services for Vietnam-era veterans. This amendment conforms subsection (g)(1)(B) to subsection (a) of section 612A, as subsection (a) was amended in 1983 by section 101 of Public Law 98-160.

Mr. President, section 612A of title 38, United States Code, provides for a VA program of readjustment counseling services for Vietnam-era veterans. Subsection (a) of section 612A sets forth the basic eligibility criteria. As originally enacted in Public Law 96-22 which I authored, this section provided that veterans who requested readjustment counseling within 2 years of their date of discharge from the service or by September 30, 1981, as to those already discharged by October 1, 1979—the situation for the vast majority of Vietnam-era veterans—would be furnished such counseling by the VA.

In 1981, in recognition of a continuing need for the VA's readjustment counseling program, I proposed in S. 458, 97th Congress, and Public Law 97-72 enacted, an extension of the September 30, 1981, end-of-new eligibility date by 3 years, until September 30, 1984. In addition to the extension of the eligibility period, Public Law 97-72 also mandated that the VA study how to meet Vietnam-era veterans' readjustment needs after the September 30, 1984, eligibility expiration date and to submit a report to Congress by April 1, 1984, on its plans in that regard.

In 1983, because of my concerns that the VA would not be able, prior to the 1984 eligibility expiration date, to complete a comprehensive evaluation, as contemplated by Public Law 97-72, of the continuing needs of Vietnam-era veterans for readjustment counseling assistance, I introduced legislation, S. 11, 98th Congress, which included in section 201 a provision for a further, short-term extension of the period of eligibility. Legislation providing such an extension was passed by the Senate as was similar legislation by the House. During our efforts with our counterpart committee in the House to develop a compromise agreement, it became clear both that the VA could not conduct the type of evaluation the Congress desired in the timeframe contemplated by the extensions passed by either House and that there was a need to send an unequivocal message to veterans served by the readjustment counseling program as well as to those working in it that the Congress had a continuing commitment to the program.

Thus, the committees included in the measure enacted as Public Law 98-160 a provision that totally eliminated any expiration date on the eligibility for readjustment counseling, thereby providing Vietnam-era veterans with ongoing eligibility to request readjustment counseling at any time. In addition, that law postponed for 4 years, from fiscal years 1984 to 1988, the period during which the Administrator is required in section 612A(g), first, to plan for the transition of the readjustment counseling program from a program run primarily through storefront vet centers to a program run primarily through VA hospitals and clinics; and, second, to ensure "the continued availability * * * of readjustment counseling and related health services under this section."

By inadvertence, subsection (g)(1)(B) when amended was not conformed in its language to delete a reference to the expiration date for eligibility to request readjustment counseling which was being repealed in subsection (a). On its face, then, subsection (g)(1)(B) now limits the Administrator's responsibility during fiscal year 1988 to plan for ensuring "the continued availability" after fiscal year 1988 of readjustment counseling and related services so that that responsibility pertains only to Vietnam-era veterans who request counseling by the end of fiscal year 1988. The amendment I am proposing today will correct this oversight and conform subsection (g)(1)(B) to subsection (a) by explicitly requiring the Administrator during fiscal year 1988 to plan for the continued availability of such services thereafter for all Vietnam-era veterans, regardless of when they initially request counseling.

Mr. President, I ask unanimous consent that a paper showing the changes that the amendment would make in existing law be printed at this point in the RECORD.

There being no objection, the paper was ordered to be printed in the RECORD as follows:

CHANGES IN EXISTING LAW MADE BY AMENDMENT NO. 22

(Existing law proposed to be omitted is enclosed in brackets, and existing law in which no change is proposed is shown in Roman.)

§612A. Eligibility for readjustment counseling and related mental health services

(a) Upon the request of any veteran who served on active duty during the Vietnam era, the Administrator shall, within the limits of Veterans' Administration facilities, furnish counseling to such veteran to assist such veteran in readjusting to civilian life.

* * * * *

(g)(1) During the twelve-month period ending on September 30, 1988, the Administrator shall take appropriate steps to ensure—

* * * * *

(B) the continued availability after such date of readjustment counseling and related mental health services under this section to veterans eligible for the provision of such counseling and services who request[ed] such counseling [before such date].

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[19B]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 22 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 6, 99th Congress, a bill entitled the "Veterans' Administration Health-Care Amendments of 1985," and Amendment No. 22 to this bill. This bill contains a number of major provisions relating to the VA health-care program.

VA favors section 2 of the bill which would expand the definition of the Vietnam era, and favors the major purpose of section 5 of the bill to extend VA's authorities to contract for halfway house care for veterans with alcohol or drug abuse dependence or disabilities. VA has no objections to section 4, which would extend through Fiscal Year 1989 the special eligibility period for veterans exposed to dioxin or other toxic substances, or to nuclear radiation, to receive VA health care. Finally, we favor Amendment No. 22, which would clarify an ambiguity in the law that now appears to limit readjustment counseling services to certain Vietnam-era veterans after September 30, 1988.

We oppose section 3 of the bill, which precludes the Agency from implementing any systematic reduction of VA employee pay grades without first submitting to the Veterans' Affairs Committees a plan and justification for the proposed reduction. We also oppose both section 7 regarding disclosure of medical quality-assurance records as well as section 8 relating to disciplinary proceedings under section 4110 of title 38, United States Code, involving clinical privileges. Finally, we oppose section 9, which would require VA to conduct a pilot health-care demonstration program and section 10 of the bill, which would direct VA and the Departments of Defense and Health and Human Services to submit a joint report to Congress on providing services to certain civilians who served in Vietnam during the Vietnam era.

First, section 2 of the bill would expand the legal definition of the term "Vietnam era" to include the period from February 21, 1961, through August 4, 1964, if the veteran served in

Vietnam during that time. VA supports this change in the law. We estimate that approximately 48,000 veterans served in Vietnam between February 21, 1961, the date established in Public Law 89-527 for acceptance of awards from foreign governments for service in Vietnam, and August 5, 1964, the date of the Gulf of Tonkin Resolution. Those veterans served under adverse conditions which can be considered akin to wartime conditions. It is reasonable that they be eligible to receive benefits for which wartime service in general, and Vietnam-era service in particular, is a requirement.

Veterans covered by this provision would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they also meet disability, income, and net worth requirements. Other benefits they might receive include certain burial benefits, readjustment counseling services, medical benefits under Public Law 97-72, and loan guaranty benefits in certain cases. The number of veterans who would be affected and who are not otherwise eligible for these benefits is not large. The estimated cost for these additional benefits is approximately $1.3 million for each of the next five fiscal years.

Section 3 of the bill would prohibit VA from implementing any systematic reduction of Agency employees in any pay grade unless VA first submits to both Committees on Veterans' Affairs, at least ninety days before implementing a reduction, a report containing a detailed plan and justification for the reduction demonstrating that VA has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to equivalent employees in other Federal agencies and non-Federal entities. Furthermore, this section directs the Comptroller General to submit to the committees, within 45 days after the submission of this report, a report on VA's compliance with this provision and an opinion on the accuracy of the Agency's determination.

Section 3 would inject the Congress into a management function, and VA opposes it. Obviously, any steps to control grade levels must be the object of careful study, but the analysis properly can and should be accomplished within an executive agency and not be conditioned upon any report to the committees of the Congress.

We also consider the definition of a grade reduction in section 3 of the bill to be overbroad. Arguably, this definition could be interpreted to require an advance report and determination as to virtually any systematic action which would result in grade reductions. Specifically, it could prevent us from reorganizing work, implementing new classification standards, complying with classification consistency review requirements directed by Office of Personnel Management, or generally reclassifying positions properly if any of the actions would result in a lower grade structure for any group of employees.

Section 4 would extend for almost three years the eligibility period for certain veterans who were exposed either to dioxin or other toxic substances while serving in Vietnam during the Vietnam era, or to ionizing radiation from nuclear detonation, to receive priority VA health-care services for disabilities not determined to be unrelated to that exposure. Currently, this eligibility period expires one year after the submission of a Congressionally mandated report on the epidemiological study being conducted by the Center for Disease Control (CDC) of the effects of exposure to dioxin on Vietnam veterans. The first report is due 24 months after the protocol for the study was approved, which was on February 24, 1984. Therefore, this health-care eligibility is scheduled to expire on February 24, 1986.

We believe that the necessary information for this study will not be sufficiently advanced by 1986 to permit Congress and the Administration to make final decisions on care for these veterans. The expiration date recommended by this provision--September 30, 1989--is based on the premise that, if, as planned, the CDC reports on the epidemiological study by September 1988, then Congress would have sufficient time to evaluate the results of that study and other relevant information and decide if further action may be needed. This proposed extension would permit Congress and the Administration to have sufficient time to analyze the results of the study and make a decision regarding health care for these veterans prior to the expiration of their eligibility. Thus, we have no objection to this provision. We estimate the cost of this extension to be $69.6 million for Fiscal Year 1987 and for each of the next two fiscal years for a three-year total cost of $209 million.

Section 5 of the bill would extend for three years, until the end of Fiscal Year 1988, VA's current authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority expires on September 30, 1985. A similar provision was passed by the Senate last year. We strongly support the extension of VA's authority to operate this program and have submitted legislation to extend this authority through Fiscal Year 1988. Our estimated cost for this provision is $6.1 million for each of the next three fiscal years.

Honorable Frank H. Murkowski

Since April 1980, the VA has operated a program authorized by Public Law 96-22 under which certain veterans suffering from alcohol and drug dependence have been provided treatment and rehabilitation in community contract facilities such as halfway houses. In authorizing its establishment, Congress called for VA to plan and operate a pilot program so as to demonstrate both the medical advantages and cost-effectiveness of this care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program. The required study indicated that those patients who were placed under this program were, on the whole, least able to cope in society.

VA prides itself on the quality of care of our substance abuse programs. Nevertheless, our study tends to show that, for approximately five percent of VA patients admitted for substance dependence or abuse disabilities who are essentially alienated from society, many without family support and with no job in the community, contract halfway house care with its peer setting can greatly help reentry into the community and acquisition of self-help and job skills. This five percent minority tends to reenter more successfully the job market and the community from halfway house care than from VA hospitals. We have found that the halfway house provides more definitive rehabilitation of recovery-resistant cases requiring continued residential support and extensive work on self-help skills. It also offers economic advantages of shortening the total VA hospital-bed days by providing treatment and rehabilitation in a lower cost residential environment.

As of the end of Fiscal Year 1984, 83 VA medical centers had contracts with 297 non-VA community-based programs, and 16,685 veterans had been outplaced for treatment in these contracted facilities. The program evaluation study revealed strongly encouraging followup measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse-prone veterans to warrant continued authorization for this program.

This provision would also require the Administrator to submit reports for Fiscal Years 1985, 1986 and 1987 to the Veterans' Affairs Committees on findings and recommendations on the operations of the program. Each report must include information on the average duration of veterans' participation in the program, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contract. We wish to point out that, while the data on average lengths of stay in contract programs can be collected directly from the VA medical centers using the contract authority, determining the rates of successful rehabilitation for veterans outplaced in non-VA community-based programs, as required by the bill, would be much more difficult and costly. For example, alcoholic veterans who are to be contacted and assessed for level of recovery and other treatment-related measures are often difficult to locate after discharge from the non-VA halfway houses. During Fiscal Year 1984, 5,770 veterans were outplaced into halfway houses after acute care at VA medical centers.

Section 7 would amend section 3305 of title 38, which generally prohibits disclosure of medical quality-assurance records, to the extent that they are designated confidential by VA regulations. Implementing regulations provide for the release of aggregations of statistical data from quality-assurance studies and reviews except where those statistics would, by implication, reflect on the care and treatment being provided by a particular practitioner. Section 7 of the bill would overrule this regulation by requiring that all quality-assurance mortality and morbidity statistics for specific activities at individual VA hospitals be made public. No exception is provided. If this provision is enacted, the mortality and morbidity statistics (that is, the incidence by percentage of death or disease in a program) in a relatively small, single-provider program, such as cardiac surgery, would be publicly available and would reflect directly on the provider in that program. Particularly in major surgeries, such as cardiac surgery, we believe that an individual patient should be apprised of these statistics as they relate to his or her care. We believe further, however, that the VA quality-assurance review of the small, single-provider program will be seriously and detrimentally affected if such statistics must be made public. Accordingly, we strongly oppose enactment of this provision.

The compilation of mortality and morbidity statistical data reflects medical judgment. For example, when reporting mortality/morbidity statistics for a cardiac surgery program, a death, the underlying cause of which is cardiac surgery, but the immediate cause of which is pneumonia, could be reported as the result of pneumonia rather than complications resulting from the surgery. Such would reduce the cardiac surgery mortality rate. The public availability of this potentially critical data on individual providers will be a factor for consideration by other providers when they exercise their judgment on how to "count" their peer's patient mortality. We believe that this will, in fact, significantly influence the mortality and morbidity statistics reported in small, single-provider programs.

It should be pointed out that the Agency is currently developing an additional quality-assurance mechanism know as the Peer Review Organization (PRO). It is anticipated that this process will engender provider-specific statistics for all VA physicians. For the aforementioned reasons, we are concerned about the Agency's ability to garner accurate statistics in the PRO process if section 7 of S. 6 is adopted.

We believe that enactment of section 7 of this bill would also detrimentally affect other areas pertaining to patient care that are not related solely to the VA quality-assurance program.

These concerns include the fact that public availability of provider-specific data would have a chilling effect on the ability of the VA to retain physicians and other health care professionals. As you are aware, the performance of private practitioners in the community is not subject to public disclosure. Additionally, we believe that this statistical data could easily be misinterpreted by the veteran. As a consequence, such a veteran may well be dissuaded unnecessarily from seeking appropriate treatment. We are also concerned that surgical mortality rates may become public indicia for assessing the care at a facility. Such a practice could discourage the use of surgery for high risk patients even though it is medically and ethically appropriate.

In considering the need for confidentiality for provider specific statistical data, it should be noted that at least one other Government agency faced concerns similar to VA's and has recently provided protection for such data.

The debate in the private sector has been ongoing for nearly ten years with respect to the release of statistical data collected first by Professional Standards Review Organizations (PSROs), and now PROs, under the Medicare program. The Department of Health and Human Services (DHHS) recently published regulations (to be codified at 42 C.F.R. Part 476) which implement section 1160 of Title XVIII of the Social Security Act (Medicare). These regulations are nearly identical to VA's with respect to release of statistical data. DHHS rules provide that the PROs must disclose nonconfidential information to any person upon request, except aggregate statistical information that implicitly or explicitly identifies individual patients, practitioners, or reviewers.

Finally, we believe that the existing regulatory provision, i.e., 38 C.F.R. § 17.518(b), is adequate because it provides a reasonable balance between the public's need to hold the Agency accountable (e.g., through Congressional oversight) and the need of the Agency to protect the peer review process and the quality assurance program.

Section 8 of the bill would provide that the procedures set forth in section 4110 of title 38, relating to disciplinary board proceedings involving VA physicians, dentists, nurses, and certain other VA health-care personnel employed under the title 38 personnel system for inaptitude, inefficiency, or misconduct, would also apply to cases involving proposed reductions or revocations in the clinical privileges of these personnel for the same charges. Under this provision, a disciplinary board could not impose a reduction or revocation of clinical privileges unless the person charged has been provided notice prior to the hearing and the reduction or revocation is on the basis of deficiency in clinical practice.

We believe that privileging is a clinical management function for quality patient care and for accreditation as required by the Joint Commission on the Accreditation of Hospitals (JCAH). Recognizing this, the Department of Medicine and Surgery (DM&S) has appointed a Director for Quality Assurance who reports to the Chief Medical Director and whose office will work with VA medical centers to review the quality of their clinical privileging program.

We also believe that a disciplinary board proceeding is not the proper forum for the review of clinical privileges. In our view, the authority to decide on clinical privileges should remain with the facility's chief of staff, aided by local peer review through a professional standards board. Policies and procedures on approval and review of clinical privileges are included in each VA medical center's bylaws as required by the JCAH. JCAH requires that the bylaws include provisions for (1) a fair hearing, and (2) appellate review in the event of a recommendation adverse to the employee/applicant. Typically, the VA facility implementation is a peer review process with a hearing and appeal available where there has been an adverse determination. The Associate Chief Medical Director for Quality Assurance will be issuing guidance emphasizing these process requirements.

Generally, however, the review and delineation of clinical privileges is a joint cooperative process with the employee seeking approval of proposed privileges. It is designed, and in the vast majority of cases operates, to protect against arbitrary withdrawal of privileges, without sacrificing the overriding priority, which is the well-being of VA patients.

This proposal would remove this decision-making authority from the local facility and vest it with the Chief Medical Director, with appeal to the Administrator. Not only would this change have substantial operational consequences with a substantial loss in flexibility; but more significantly, it could result in a sacrifice of the confidentiality essential for effective quality assurance oversight. Discipline under section 4110 concerns a professional's employment status and is based on culpable inaptitude, inefficiency and/or misconduct. The privileging process concerns the capacity to treat patients and is based on an individual's clinical competence in a particular hospital activity as the result of his or her professional training and experience. These proposed new procedural requirements could delay the withdrawal of clinical privileges even if the health and safety of veteran patients were threatened. We believe these processes, the privileging on the one hand, and the disciplinary on the other, are properly separate and should remain separate. We strongly oppose this provision.

Section 9 of this bill would require VA to conduct a 48-month pilot demonstration program in at least 5 geographic regions through which participating veterans would receive appropriate health and health-related services such as homemaker, personal care, and transportation services, from VA and appropriate public and private agencies. The express purpose of this program is to enable VA to evaluate the effectiveness, feasibility, and desirability of various actions that would provide veterans needed care in noninstitutional settings. VA would be required to report to Congress on the results of this program, with recommendations for appropriate administrative and/or legislative action, no later than 39 months following the commencement of the program. Section 9 calls for an authorization up to $10 million for this program for Fiscal Year 1987 and such sums as may be necessary for each of the subsequent four fiscal years.

VA favors the basic concept of developing alternatives to institutional care. We have submitted draft legislation to Congress which would establish a pilot program to provide veterans with an alternative to nursing home care by authorizing VA to conduct a three-year pilot test of respite care. VA also has several other programs to achieve these purposes, including adult day health care and hospital-based home care as alternatives to institutional care. Accordingly, we see no need for this provision.

Although section 9 would provide VA with the means to evaluate the benefits of providing new health-related services, the provision is unduly prescriptive in directing the scope and operation of the pilot program. We see no need for Congress to mandate minimum numbers of geographic areas or VA geriatric evaluation units to be included, for example. In many respects, the requirements of section 9 are so specific that they deprive VA of the latitude needed to derive real benefit from any such pilot program.

Finally, we cannot favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources. However, the estimated cost of the program proposed under section 9 of the bill would be $4.3 million for Fiscal Year 1987 and $5.7 million for each of the next three fiscal years. We cannot justify the shifting of resources from our existing facilities and ongoing programs in order to establish this pilot program.

Section 10 of S. 6 would direct VA and the Departments of Defense and Health and Human Services to submit a joint report to Congress on alternatives whereby the Government might provide services, such as health-care and monetary compensation for disabilities incurred, to Government employees and other civilians who served in Vietnam during the Vietnam era. We oppose this provision for several reasons. First, Title IV of Public Law 95-202 established a means for members of civilian support elements to apply to the Secretary of Defense for recognition of alternative service to establish veteran status. Second, we are unaware that civilians who served in organizations, like the Red Cross, are in such need of assistance for health insurance or other benefits, beyond what their own organization may provide, as to warrant Federal aid. We therefore do not believe it would be prudent to expend funds of the United States Government to conduct an extensive study on a potential problem where there appears to be little evidence that a real problem exists.

The provisions of Amendment No. 22 to S. 6, which is characterized as a technical and conforming amendment, would amend section 612A(g) of title 38, United States Code, to remove three words which appear to limit the provision of readjustment counseling services after September 30, 1988, to veterans who requested such services before that date. With the enactment of Public Law 98-160, Congress specifically deleted from section 612A(a) of title 38 language which had provided that, to receive readjustment counseling services, an otherwise eligible veteran had to request those services within two years after the date of the veteran's discharge from active duty, or by September 30, 1984, whichever was later. However, subsection (g) of section 612A, which contained language listing such counseling to veterans who request it by September 30, 1988, was not amended. The amendment to section 612A in Public Law 98-160 does create some ambiguity as to whether Congress intended to retain a delimiting date for requesting counseling. The proposed amendment would clarify the matter and would be helpful. Accordingly, we favor the provision.

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We do not believe enactment of this provision will have a significant budgetary impact.

We estimate the costs of this bill to be $7.4 million for Fiscal Year 1986 and $255 million for the first five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez Jr
Deputy Administrator - For
HARRY N. WALTERS
Administrator

II

99TH CONGRESS
1ST SESSION

S. 875

To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to establish and carry out a Vietnam Veterans' Resource Center pilot program.

IN THE SENATE OF THE UNITED STATES

APRIL 3 (legislative day, FEBRUARY 18), 1985

Mr. DOLE (for Mr. MURKOWSKI) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to establish and carry out a Vietnam Veterans' Resource Center pilot program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Vietnam Veterans' Resource Center Act of 1985".

VIETNAM VETERANS' RESOURCE CENTERS PILOT PROGRAM

SEC. 2. (a) Part III of title 38, United States Code, is amended by inserting after chapter 39 the following new chapter 40:

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"CHAPTER 40—VIETNAM VETERANS' RESOURCE CENTERS PILOT PROGRAM

"Sec.

"1911. Definitions.
"1912. Purpose.
"1913. Establishment of pilot program.
"1914. Vietnam Veterans' Resource Centers.
"1915. Administration of pilot program.
"1916. Report.
"1917. Regulations.
"1918. Termination.

"§ 1911. Definition

"For the purposes of this chapter, the term 'eligible veteran' means a veteran who is eligible to receive services under section 612A of this title.

"§ 1912. Purpose

"The purpose of this chapter is to increase the overall effectiveness of services furnished to eligible veterans under certain programs administered pursuant to this title by increasing the coordination of the provision of the services to eligible veterans.

"§ 1913. Establishment of pilot program

"(a) The Administrator shall, as provided in this chapter, establish and carry out a pilot program in ten readjustment counseling centers operated by the Veterans' Administration under section 612A of this title to furnish the services referred to in subsection (b) of this section to eligible veterans and to coordinate the provision of such services to such veterans.

"(b) The following services shall be available and coordinated under the pilot program:

"(1) Readjustment counseling and related mental health services authorized by section 612A of this title.

"(2) Treatment and rehabilitation for alcohol or drug abuse dependence or alcohol or drug abuse disabilities.

"(3) Employment counseling, training, and placement services described in section 2003A of this title, in cooperation with employees of the Department of Labor referred to in such section.

"(4) Outreach and other services authorized to be provided by veterans' benefits counselors of the Veterans' Administration.

"§ 1914. Vietnam Veterans' Resource Centers

"(a)(1) In carrying out the pilot program required by section 1913 of this title, the Administrator shall redesignate each of the readjustment counseling centers selected pursuant to subsection (a) of such section as a Vietnam Veterans' Resource Center, shall convert the mission of the ten readjustment counseling centers to carry out the pilot program, and shall transfer the functions and administration of the ten readjustment counseling centers under section 612A of this title to the Vietnam Veterans' Resource Centers.

"(2)(A) The staff of each Vietnam Veterans' Resource Center shall include—

"(i) personnel provided under section 612A of this title;

"(ii) an employee or employees of the Department of Veterans' Benefits of the Veterans' Administration experienced in career development and vocational rehabilitation and counseling;

"(iii) one or more veterans' benefits counselors of the Veterans' Administration;

"(iv) an employee or employees of the Veterans' Administration qualified in alcohol and drug abuse counseling, treatment, and rehabilitation.

"(B) The director of a Vietnam Veterans' Resource Center may, in consultation with the medical director of the appropriate Veterans' Administration medical center or the director of the appropriate Regional Office of the Veterans' Administration, assign a member of the staff of a Vietnam Veterans' Resource Center to work part time in a Veterans' Administration Medical Center or Regional Office, scheduling the work time of the member in each facility as needed. The primary responsibility of any member of the staff so assigned shall be to furnish services to eligible veterans in the Vietnam Veterans' Resource Center under the pilot program.

"(3) Each individual who, when a readjustment counseling center is redesignated as a Vietnam Veterans' Resource Center under paragraph (1) of this subsection, is serving as a team leader of the readjustment counseling center shall be the director of that center. If a director of a Vietnam Veterans' Resource Center terminates employment, transfers to another position, or otherwise becomes unavailable to serve in the position of director, the Administrator shall designate any qualified member of the professional staff of the Vietnam Veterans' Resource Center as director of the center.

"(b) A Vietnam Veterans' Resource Center shall furnish unified case management for each eligible veteran residing within the geographic area served by the center and requesting or receiving services referred to in section 1913(b) of this title, including any such services furnished under contract. Case management shall include the provision of and the coordination of the provision of the services, referral for the services, and followup functions. In furnishing unified case management to eligible veterans, the staff of a Vietnam Veterans' Resource Center shall cooperate with disabled veterans' outreach program specialists authorized by section 2003A of this title. The Administrator may request the Secretary of Labor to assign, and the Secretary of Labor may assign, disabled veterans' outreach program specialists to

Vietnam Veterans' Resource Centers as appropriate to carry out the purpose of the pilot program.

"§ 1915. Administration of pilot program

"(a) The Deputy Administrator of Veterans' Affairs shall administer the pilot program required by section 1913 of this title.

"(b) The Administrator shall detail to the Office of the Deputy Administrator of Veterans' Affairs such employees of the Veterans' Administration qualified in case management as the Administrator considers appropriate to assist the Deputy Administrator in the administration of the pilot program. The Administrator shall include among employees detailed to the Office pursuant to the first sentence at least one representative from the Department of Medicine and Surgery of the Veterans' Administration and at least one representative of the Department of Veterans' Benefits of the Veterans' Administration.

"(c) In the administration of the pilot program, the Deputy Administrator shall consult with the head of the office in the Department of Medicine and Surgery carrying out section 612A of this title and shall take into consideration the goals and objectives prescribed by such office to carry out such section.

"§ 1916. Report

"(a) Not later than April 1, 1987, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the pilot program.

"(b) The report required by subsection (a) of this section shall include—

"(A) the Administrator's findings on—

"(i) the effectiveness of the pilot program in coordinating the provision of the services referred to in section 1913(b) of this title to eligible veterans; and

"(ii) the cost effectiveness of the program;

"(B) a description of any administrative actions the Administrator plans to take to increase the coordination of the provision of such services to eligible veterans and to other veterans;

"(C) any recommendations for legislation, relating to the provision of such services to eligible veterans and to other veterans, the Administrator considers appropriate; and

"(D) a comparison of such findings, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by section 612A(g)(2) of this title.

"§ 1917. Regulations

"The Administrator shall promulgate such regulations as the Administrator considers appropriate to carry out the pilot program required by section 1913 of this title.

"§ 1918. Termination

"The pilot program established and carried out under this chapter shall terminate three years after the date the program is established.".

(b) The table of chapters at the beginning of such title and at the beginning of part III of such title are each amended by inserting after the item relating to chapter 39 the following new item:

"40. Vietnam Veterans' Resource Centers Pilot Program .... 1911.".

EFFECTIVE DATE

SEC. 3. The amendments made by section 2 shall take effect 90 days after the date of enactment of this Act. The Administrator of Veterans' Affairs shall establish and commence the pilot program required by chapter 40 of title 38, United States Code (as added by such amendment), on such effective date.

[From the Congressional Record, Vol. 131, No. 41, pp. S4027-S4028--Senate, April 3, 1985]

S. 875. A bill to amend title 38, United States Code, to require the Administrator of Veterans' Affairs to establish and carry out a Vietnam Veterans' Resource Center Pilot Program; to the Committee on Veterans' Affairs.

VIETNAM VETERANS' RESOURCE CENTER ACT

Mr. MURKOWSKI. Mr. President, today I am introducing a bill to establish a pilot program of Vietnam Veteran Resource Centers [VVRC]. These centers would use existing vet center sites to explore a new concept in providing better service more efficiently to eligible Vietnam veterans.

Under current law, the VA has 187 satellites and storefront vet centers which provide readjustment counseling to Vietnam veterans who have had difficulty readjusting to civilian life. The underlying goal of these very successful centers has been to attract veterans who shied away from VA hospitals and regional offices but were having difficulty with their lives. Many of these veterans have been found to be suffering from posttraumatic stress disorder [PTSD] as a result of their combat experiences. The vet centers have provided an avenue for these veterans to come back to the mainstream of life and to be referred to VA medical centers or regional offices if they need specific services other than readjustment counseling.

Mr. President, the Vet Center Program was established by Congress by Public Law 96-22 and is due to expire on October 1, 1988. At this time, the services provided in these storefront centers will remain available, but within the confines of VA medical centers. Before the program expires, the Administrator of the Veterans' Affairs shall submit to the Congress a report that will provide some insights with respect to the extent to which the readjustment needs of such Vietnam veterans have remained unmet, the extent to which the provision of readjustment counseling services is needed to meet such needs and, finally, a recommendation for legislative or administration action that could affect the continuation of such services.

I have designed this additional legislation to meet the changing needs of Vietnam veterans, some of whom have been struggling to find their place in civilian society for longer than 10 years. My proposal incorporates the very positive aspects of the current Vet Center Program. Initially, I do believe it was appropriate to offer psychological readjustment services to such veterans and, in fact, I think these services may still be appropriate and are incorporated in my proposal. However, experience has taught us that psychological services are only one of a number of services which could benefit veterans who seek assistance through community vet centers providing a broad range of services. For example, a Vietnam veteran who is having problems may also be out of a job, may not have taken advantage of his or her VA benefits and may, as a result of these problems, be grappling with some substance abuse which only adds to complicate the readjustment process. It seems only logical to me that if we are to set up storefront community centers for Vietnam veterans that the mandate include a broad spectrum of services under one roof—a one-stop service point combining the resources of the VA's Departments of Medicine and Surgery [DM&S], Veterans Benefits [DVB], as well as the Department of Labor [DOL] employment specialists. By providing a complete spectrum of services, VVRC's would emphasize that Vietnam veterans are not unlike other citizens, in that psychological problems can be traced to concrete life problems and need to be dealt with in that context. This is the most likely way to successfully overcome any psychological barriers which may exist to complete integration into our society as a responsible citizen. These centers would address the full range of problems a veteran may face.

Mr. President, I have intended that this program be a 3-year pilot program to coincide with the end of vet center services as they exist under current law. As the VA and the Congress weigh the necessity for this program to continue in its present or another form, the usefulness of a case management approach can be incorporated into recommendations regarding the future of vet center services and their relevance for Vietnam and other veterans as well. This bill contains a reporting requirement to ensure that the recommendations are transmitted to the Congress and are coordinated with the recommendations that are required under the Readjustment Counseling Program.

Mr. President, this idea is not mine alone. I owe the germination of these thoughts from many experts in Washington and in the field who run vet center programs, the veterans who have participated in them and the many fine representatives of veterans organizations, all of whom share a responsibility for the development of this concept. I am grateful for their input and I believe that an examination of this new model for VA services will provide benefits beyond those of the pilot program.

My bill would expand the readjustment counseling services to include the availability of employment counseling, training and placement; outreach and other services as provided by veterans benefits' counselors; and the treatment and rehabilitation for alcohol and drug abuse dependence. Some vet centers have already determined a need for some of the services in my bill and offer them on an ad hoc basis to their veteran clientele; however, services beyond readjustment counseling are not mandated by law and often employees are not qualified to provide them. The main difference that would be provided by this bill is that in each VVRC there would be qualified employees in the above-mentioned areas available, either part time or full time, as needed, to provide a wide range of services to interested and eligible veterans.

Currently vet centers are administered under the auspices of the Department of Medicine and Surgery. The VVRC's would operate under a totally new concept. The program's central office administration would be under the Deputy Administrator of Veterans' Affairs, and would include representatives from the Department of Medicine and Surgery and the Department of Veterans' Benefits who would jointly administer the program and coordinate with the readjustment counseling office in the VA. In the 10 VVRC's, the staff would furnish unified case management to eligible veterans. What this really means is that a veteran who walks in the door will be seen by someone who is qualified to determine his or her needs and would designate the appropriate employees and services within the VVRC.

Having benefits and medical services under one roof is a new idea within the VA but it makes so much sense. Why should a veteran who is in need of alcohol rehabilitation, employment counseling, and educational training have to coordinate those services on his or her own. The VA was established to be the service provider. This bill is designed to facilitate communications between DVB and DM&S personnel in order to simplify an inherently complex process. Under my proposal, a designated case manager would be assigned to the veteran when he or she walks in the door, to improve coordination of services.

Mr. President, I look forward to holding hearings on this legislation and soliciting the views of veterans' organizations and the Veterans' Administration as we strive to work together to achieve our mutual goal of providing the best service in the most efficient manner to our Nation's Vietnam veterans. Some of these veterans have had a long and arduous trip back from their service in Vietnam that has lasted many years more than any of us would have wished. We are proud of these fine citizens and want to provide them every opportunity to integrate fully into our society. I believe that this program will be a positive step in the right direction. Vietnam veterans have a variety of concerns, not unlike other citizens. I believe we must provide them every opportunity to succeed and to thank them once again for their sacrifices on our behalf.

[28]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

June 11, 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 875, 99th Congress, a bill "To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to establish and carry out a Vietnam Veterans' Resource Center pilot program." VA opposes enactment of this bill.

S. 875 would establish a three-year pilot program to convert the mission of ten of the VA's readjustment counseling centers (Vet Centers) into facilities tasked to provide on site a variety of services to Vietnam-era veterans who are eligible for readjustment counseling. The centers, which would be known as Vietnam Veterans' Resource Centers, would continue to provide eligible veterans with readjustment counseling and related mental health services, and would additionally provide drug and alcohol abuse treatment and rehabilitation; employment counseling, training, placement services, and veterans benefits outreach services. The bill provides that veterans eligible to receive services at the new centers would be limited to those now eligible for readjustment counseling services.

Administration of the pilot program in the ten new resource centers would be under the Deputy Administrator of Veterans Affairs. The "Team Leader" in each of the Vet Centers designated to become resource centers would become the Resource Center Director. The staff of each resource center would also include other persons now working in the Vet Center, personnel experienced in career development and vocational rehabilitation and counseling, one or more Veterans Benefit Counselors; and personnel experienced in drug or alcohol abuse treatment, counseling and rehabilitation. The bill would also authorize the Secretary of Labor to assign disabled veterans outreach program specialists to the centers.

The concept of converting some Vet Centers into expanded one-stop service centers has a certain appeal. Nevertheless, we see serious problems in both the concept as well as the specific provisions of the bill. Foremost among our concerns is that the proposal would move the Vet Centers in the direction of a self contained system autonomous from the larger VA system. We believe the readjustment counseling program has greatly improved, in part through VA having achieved greater integration and coordination between that program and the overall VA system. We believe that the direction we have taken with that program offers the greatest capacity to assist veterans.

In contrast, the approach proposed by S. 875 would be very costly to establish, manage, and evaluate. We do not believe that the experience we might gain from operating such a pilot program would outweigh the costs, particularly in light of other demands on these resources. Finally, we believe that Vet Centers are already successfully carrying out many of the functions which this bill would mandate and we see little reason to conduct an experiment of this magnitude.

It is important to understand that many Vet Centers now provide a combination of services to the veteran associated with readjustment counseling. In that connection, we note that 120 Vet Centers now have a Department of Labor employee working at the Vet Center on a regular basis for a set number of hours per week performing employment counseling. In addition, a number of Vet Centers have an employee from the Department of Veterans Benefits working regularly to provide benefits counseling. In a few instances, substance abuse counseling is provided if the Vet Center counselor on staff has the necessary qualifications to provide such counseling. We strongly believe that local program managers should be left with the discretion to provide the services they deem necessary in the most effective and efficient manner possible. It may be more difficult and more costly to provide services outside the medical center or regional office setting, and we do not believe broad based service delivery by Vet Centers should be mandated. One major reason for the success of the Vet Centers over the past five years has been the sharp focus of their mission. We believe that the pilot program would tend to diffuse that mission and thus not take account of an important lesson that has been learned. Finally, separate and apart from the merits of the pilot program, we are uneasy with the organisational scheme under which such a program would be administered.

VA estimates the cost of S. 875 to be $2.8 million in the first fiscal year and $6.7 million for the three years that the pilot program would be conducted.

Honorable Frank H. Murkowski

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez Jr. Deputy Administrator • For

HARRY N. WALTERS
Administrator

Enclosures

PROJECTED COST OF THE RESOURCE PILOT PROGRAM 5/28/85
(Bill S.875)

SUMMARY

Salary (recurring)———— $1,471,740

All-Other (recurring)——— 348,410

All-other (non-recurring)— 945,000

Total FY 86 ———————— $2,765,150

Total FY 86 Travel———— $ 25,000

Total FY 87———————— $1,820,150 (minus non-recurring start-up cost)

Total FY 88———————— $1,365,113 (minus non-recurring cost and 25% reduction)

Total FY 89———————— $ 670,292 (minus non-recurring cost and 50% reduction)

SEE ATTACHED CHART (next page)

VETERANS ADMINISTRATION 5/28/85

VIETNAM VETERANS RESOURCE CENTER PILOT PROGRAM

MEDICAL CARE

(dollars in thousands)

Resource Requirements for FY	1986	1987	3/ 1988	4/ 1989
Obligations				
Vet Center Pilot Program				
Salary Cost (recurring)	1,471,740	1,471,740	1,103,805	539,638
(12.5% employment benefits)				
All-Other (recurring)	348,410	348,410	261,308	130,654
All-Other (non-recurring)	945,000	0	0	0
Total	$2,765,150	1,820,150	1,365,113	670,292
Travel (.007) 1/	25,000	25,000	18,750	9,375
Program Details				
Average Employment(FTEE) 2/	60	60	45	22
Number of V.V.R.C	10	10	7	3

1/ Average travel cost per Vet Center ($1,000 / X = 4 / 10)

2/ Additional ftee (6 additional hires at each of the 10 sites)

3/ Legislation for this program is being proposed for a period of three-years. The budget outyear (1988) would be reduced by 25%.

4/ This budget outyear (1989) would further reduce the program funds by 50%.

Non-recurring:

All-other non-recurring start-up cost are based on the average existing Vet Center expense.

NOTE:

Vet Center relocation	$20,000 x 10 = 200,000
Vet Center renovation	3,000 x 10 = 30,000
Vet Center furnishing	1,000 x 60 = 60,000
Vet Center equipment	1,500 x 10 = 15,000
Vet Center personnel relocation	10,000 x 60 = 600,000
Vet Center handicapped access	4,000 x 10 = 40,000

Total non-recurring cost $945,000

Travel cost:

$1,000/x = 4/10
4x = 10,000
x = 10,000 / 4
x = 2,500
2,500 . 10 = $25,000

PROJECTED COST OF THE RESOURCE PILOT PROGRAM

Program Requirement:

10 selected existing Vet Centers
6 additional employees at each selected site.

Cost:

Recurring

Salary cost is based on the average grade level of a GS9 step 1 ($21,804), plus retirement, social security and medicare. All salary cost projected by the present 12.5% employment benefits.

NOTE: GS9/1 $21,804 x 12.5% = 24,529 (includes all benefits)
24,529 x 6 = 147,174 (one site)
147,174 x 10 = 1,471,740 (ten sites)

Total salary cost $1,471,740

All-Other recurring cost is based on current four-person cost to include six additional employees as shown:

RENT—————— $16,864 x 10 = 168,640
UTILITIES———— 4,494 x 10 = 44,940
OFFICE OPERATIONS—— 11,236 x 10 = 112,360
SUPPLIES & OTHER—— 2,247 x 10 = 22,470

Total all-other cost $ 348,410

BEST COPY AVAILABLE

II

99TH CONGRESS
1ST SESSION

S. 876

To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health care programs.

IN THE SENATE OF THE UNITED STATES

APRIL 3 (legislative day, FEBRUARY 18), 1985

Mr. DOLE (for Mr. MURKOWSKI) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health care programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Administration Health Care Programs Improvement Act of 1985".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

ALTERNATIVE TO NURSING HOME CARE; PILOT PROGRAM

SEC. 2. (a) Section 620 is amended by adding at the end thereof the following new subsection:

"(g)(1) The Administrator shall establish and conduct a pilot program in five geographic areas to furnish medical, rehabilitative, and social services, which would obviate the need for nursing home care, to veterans who would otherwise be eligible for nursing home care pursuant to this section and who wish to participate in the program. The Administrator may—

"(A) contract for such services from non-Veterans' Administration public and private providers, where economical and high quality services and resources are available as alternatives or adjuncts to care furnished by the Veterans' Administration; or

"(B) where neither of these options is feasible, develop direct Veterans' Administration health related and supportive services designed to obviate the veteran's need for nursing home care furnished by the Veterans' Administration.

"(2) A veteran is eligible to receive services under the pilot program if the Administrator determines that—

"(A) the veteran is eligible to receive nursing home care under subsections (a) through (d) of this section;

"(B) without receiving the services furnished under paragraph (1) of this subsection, the veteran would otherwise receive nursing home care; and

"(C) as a result of receiving the services furnished under paragraph (1) of this subsection and any additional services available to the veteran in the veteran's community, the veteran would be able to reside at home in a substantially self-sufficient manner.

In administering the program, the Administrator shall give priority to veterans over sixty-five years of age and to veterans who are catastrophically disabled.

"(3) Each Veterans' Administration medical facility administering the pilot program in each of the five designated geographic areas shall furnish unified case management services for each veteran receiving services under the pilot program in each geographic area, including services furnished under a contract. For purpose of this paragraph, case management is defined as the coordination of all services furnished, including, but not limited to, outreach, screening, assessment of needs, planning, referral, provision for or arrangement of services, monitoring, reassessment, and follow-up.

"(4) The cost of carrying out the pilot program in any fiscal year, excluding the cost of carrying out paragraphs (5) and (6) of this subsection, may not exceed 60 percent of the cost that would have been incurred by the Veterans' Administration during such fiscal year, if the veterans receiving services under the pilot program had been furnished, instead, nursing home care under subsections (a) through (d) of this section.

"(5) The Administrator shall conduct a study of the program to determine—

"(A) the feasibility, medical advantages and cost-effectiveness of services as provided in this subsection as an alternative for nursing home care;

"(B) the extent to which such a program can—

"(i) improve the quality of care that such veterans receive under this section compared to the care they would otherwise receive;

"(ii) allow such veterans to receive more appropriate kinds of care under this section than they would otherwise receive;

"(iii) reduce nursing home admission rates;

"(iv) reduce the number of days that veterans to whom this section applies are hospitalized;

"(v) reduce mortality rates among such veterans; and

"(vi) reduce the cost of long-term care for eligible veterans under this section; and

"(C) the comparative advantages and disadvantages of furnishing such care through facilities that are not under the direct jurisdiction of the Administrator, and through facilities that are under the direct jurisdiction of the Administrator.

"(6)(A) Not later than eighteen months after the commencement of the pilot program required by paragraph (1) of this subsection, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the findings of the study made pursuant to paragraph (5) of this subsection. The findings of the study shall be based on the results of the first twelve months of the program. The report shall include a description of the administration of the program (including a description of the veterans receiving services under the pilot program and of the services furnished to the veterans under the pilot program), the Administrator's interim evaluation of and findings on the program (including the matters referred to in paragraph (5) of this subsection), and any recommendations for administrative or legislative action that the Administrator considers appropriate, based on the results of such program.

"(B) Not later than ninety days after the termination of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the

House of Representatives a final report on the program. The report shall include the results of the study conducted under paragraph (5) of this subsection, which shall be based on the administration, evaluation and findings of the program for the entire period of the program.

"(7) The pilot program shall commence January 1, 1986, and shall terminate December 31, 1988.".

(b) The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 620 and inserting in lieu thereof the following:

"620. Transfers for nursing home care; adult day health care; alternative to nursing home care; pilot program.".

TREATMENT AND REHABILITATION FOR ALCOHOL OR DRUG DEPENDENCE DISABILITIES

SEC. 3. (a)(1) Section 620A(a)(1) is amended—

(A) by striking out "pilot" in the first sentence; and

(B) by striking out the second sentence.

(2) Section 620A is further amended by striking out subsections (e) and (f) and inserting in lieu thereof the following:

"(e) The Administrator shall monitor the performance of programs operated by each contract facility furnishing care and services under this section to determine—

"(1) with respect to the programs, the medical advantages and cost effectiveness that result from furnishing care and services in contract facilities, rather than in Veterans' Administration facilities;

"(2) with respect to contract facilities—

"(A) the level of success of each contract facility under the program, considering—

"(i) the rate of successful rehabilitation for veterans who have received the contract facilities' care and services under the program for disabilities referred to in subsection (a) of this section;

"(ii) the rate of readmission to each contract facility program by such veterans (with respect to such disabilities);

"(iii) whether the treatment and services furnished by contract facilities obviated the need of such veterans for hospitalization for such disabilities;

"(iv) the ability of the program to aid in the transition of such veterans back into their communities;

"(v) the average duration of the treatment that such veterans have received from the contract facility under the program; and

"(vi) any other factors the Administrator considers appropriate;

"(B) the total cost for the care and services furnished by each contract facility;

"(C) the average cost for each veteran receiving care and services furnished by contract facilities; and

"(D) the appropriateness of such costs, by comparison to—

"(i) the charges for the same care and services furnished generally by other halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities in the same geographic area; and

"(ii) the historical costs for such services for the period of time that this program was a pilot program, taking into account economic inflation.

"(f) The Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the administration of this section, including, but not limited to, a description of the care and services provided; the matters referred to in subsection (e) of this section, and the Administrator's findings, evaluation, and recommendations on the program.".

(3) Subsection (g) of such section is amended—

(A) by striking out "(g) The" and inserting in lieu thereof "(g)(1) Subject to paragraph (2) of this subsection, the"; and

(B) by adding at the end thereof the following new paragraph:

"(2) The Administrator may not enter into contracts under this section which would exceed a total program level of $10,000,000 in any fiscal year.".

(b) The table of sections at the beginning of chapter 17 is amended by striking out "; pilot program." and inserting in lieu thereof a period for the item relating to section 620A.

COMMUNITY RESIDENTIAL CARE PILOT PROGRAM FOR CHRONICALLY MENTALLY ILL VETERANS

SEC. 4. (a) Section 630 is amended—

(1) in subsection (b)(1), by striking out "subsection (a) of"; and

(2) by adding at the end thereof the following new subsection:

"(g)(1) The Administrator shall establish and conduct a pilot program in five geographic areas under which the Administrator may contract for care to be furnished in community residential care facilities to eligible veterans suffering from chronic mental illness and who wish to participate in the program. Notwithstanding subsection (b)(3) of this section, the Administrator shall pay to each facility the charges for such care. The Administrator shall prescribe regulations to carry out this subsection, as authorized by, and in accordance with, subsection (d) of this section. In each geographic area, such program shall also involve the use of Veterans' Administration psychiatric day treatment and hospital-based home care programs.

"(2) A veterans is eligible to receive care under the pilot program if the Administrator determines that—

"(A) the veteran is suffering from chronic mental illiness and is eligible to receive care under section 610,

"(B) without receiving the care furnished by a community residential care facility under paragaph (1) of this subsection, the veteran would otherwise receive hospital or nursing home care in a Veterans' Administration facility, and

"(C) by receiving the care furnished by a community residential care facility under paragraph (1) of this subsection and any additional services available to the veteran in the veteran's community, the veteran eventually would be able to reside at home in a substantially self sufficient manner.

"(3) Each Veterans' Administration medical facility administering the pilot program in each of the five designated geographic areas shall furnish unified case management services for each veteran receiving care under the pilot program, including care furnished under a contract. For purposes of this paragraph, case management is defined as the coordination of all services furnished, including, but not limited to, outreach, screening, assessment of needs, planning, referral, provision for or arrangement of services, monitoring, reassessment, and followup.

"(4)(A) Not later than eighteen months after the commencement of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the pilot program. The report shall include a description of the administration of the pilot program during the first twelve months of the pilot program, a description of the geographic areas where the pilot program is being carried out, the costs of the pilot program, and the Administrator's findings and evaluations with respect to (1) the quality of care furnished under the pilot program to eligible veterans, and (2) the effectiveness of the pilot program in maintaining such veterans in their communities and in obviating the need for readmission to Veterans' Administration medical facilities.

"(B) Not later than ninety days after the termination of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a final report on the pilot program. The report shall include the Administrator's findings on the effectiveness of the pilot program (relating to the matters referred to in the second sentence of subparagraph (A) of this paragraph) and any recommendations for administrative or legislative action that the Administrator considers appropriate based on the results of such program.

"(5) The pilot program shall commence January 1, 1986, and shall terminate December 31, 1988.".

(b) The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 630 and inserting in lieu thereof the following:

"630. Community residential care; community residential care pilot program for chronically mentally ill veterans.".

QUALITY ASSURANCE

SEC. 5. (a) Chapter 73 is amended by adding at the end thereof the following new subchapter:

"SUBCHAPTER V—QUALITY ASSURANCE

"§ 4151. Responsibilities

"(a) The Administrator shall—

"(1) establish and conduct a comprehensive quality assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery to eligible veterans;

"(2) delineate the responsibilities of the Office of the Inspector General of the Veterans' Administration and the Department of Medicine and Surgery with respect to the monitoring, evaluation and conduct of the

Veterans' Administration quality assurance program conducted by the Department of Medicine and Surgery;

"(3) allocate—

"(A) sufficient resources, and personnel with skills and qualifications necessary to review a medical quality assurance program, to enable the Office of the Inspector General to monitor the quality assurance program conducted by the Department of Medicine and Surgery, and

"(B) sufficient travel funds to enable the Department of Medicine and Surgery to carry out its quality assurance responsibilities and to enable the Inspector General to monitor the quality assurance program conducted by the Department of Medicine and Surgery.

"(b) The Administrator shall, as part of the comprehensive quality assurance program established and conducted pursuant to subsection (a)(1) of this section, require the Chief Medical Director of the Department of Medicine and Surgery—

"(1) to establish mortality and morbidity rate norms to be used as standards for all surgery programs conducted by the Department of Medicine and Surgery;

"(2) to collect data on mortality and morbidity rates for each surgery program including, but not limited to, each cardiac surgery program conducted by the Department of Medicine and Surgery, and information pertaining to and an analysis of—

"(A) characteristics of the patient population,

"(B) the level of risk involved, based on the age of the patient, the kind of illness, and the severity of the illness, and

"(C) any other factors that the Chief Medical Director considers appropriate;

"(3) to compare such data to the established standards and to evaluate such data to determine whether there are any significant deviations from the standards that would indicate deficiencies in the quality of care; and

"(4) to make any recommendations based on the comparison made in paragraph (3) of this subsection.

"§ 4152. Report

"At the beginning of each fiscal year, the Inspector General of the Veterans' Administration shall review the mortality and morbidity data collected pursuant to paragraph (2) of subsection (b) of section 4151 to determine whether the mortality and morbidity statistics are within the range of the appropriate mortality and morbidity standards established pursuant to paragraph (1) of subsection (b) of section 4151, and shall submit a report to Congress on his findings.".

(b) The table of sections at the beginning of chapter 73 is amended by adding at the end thereof the following:

"SUBCHAPTER V—QUALITY ASSURANCE

"4151. Responsibilities.
"4152. Report.".

ADVISORY COMMITTEE ON VETERANS' ADMINISTRATION FACILITY PLANNING

SEC. 6. (a) Subchapter II of chapter 3 is amended by adding at the end thereof the following new section:

"§ 223. Committee on Veterans' Administration Facility Planning

"(a) The Administrator shall establish an advisory committee to be known as the Advisory Committee on Veterans' Administration Facility Planning (hereinafter in this section referred to as 'the Committee').

"(b)(1)(A) The Committee shall consist of members appointed by the Administrator from the general public, including—

"(i) representatives of veterans; and

"(ii) individuals who are recognized authorities in fields pertinent to health care policy and planning, clinical practice, and medical facility construction.

"(B) The Committee shall include, as ex officio members—

"(i) the Secretary of Defense (or a representative of the Secretary of Defense designated by the Secretary);

"(ii) the Secretary of Health and Human Services (or a representative of the Secretary of Health and Human Services designated by the Secretary); and

"(iii) the Chief Medical Director (or the Director's designees).

"(c)(1) The Committee shall review the criteria for sizing Veterans' Administration medical facilities. The review shall include—

"(A)(i) an evaluation of veterans' access to the Veterans' Administration health care system;

"(ii) an evaluation of the Veterans' Administration criteria for sizing Veterans' Administration medical facilities and the method for determining such criteria; and

"(iii) any recommendations relating to modifications in the criteria and processes.

"(d)(1) Not later than October 1 of each year, the Committee shall transmit to the Administration a report setting out the findings of the Committee during the preceding fiscal year and such recommendations for administrative and legislative action as the Committee considers appropriate.

"(2) Not later than six months after the date the annual report of the Committee is transmitted to the Administrator, the Administrator shall transmit the annual report, together with such comments on the report and such recommendations for legislation as the Administrator considers appropriate, to the Committees on Veterans' Affairs of the Senate and the House of Representatives.

"(c) The Administrator shall determine the number, terms of service, pay and allowances of members of the Committee appointed by the Administrator, and of members of the staff of the Committee, if any.

(b) The table of sections at the beginning of chapter 3 is amended by inserting after the item relating to section 222 the following new item:

"223. Advisory Committee on Veterans' Administration Facility Planning.".

EFFECTIVE DATE

SEC. 7. The amendment made by section 3 of this Act shall take effect October 1, 1985.

[From the Congressional Record, Vol. 131, No. 41, pp. S4028-S4030--Senate, April 3, 1985]

S. 876. A bill to amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health care programs; to the Committee on Veterans' Affairs.

VETERANS' ADMINISTRATION HEALTH CARE PROGRAMS IMPROVEMENT ACT

Mr. MURKOWSKI. Mr. President, as chairman of the Senate Committee on Veterans' Affairs, I am introducing today the proposed Veterans' Administration Health Care Programs Improvement Act of 1985. This legislation is intended to improve the VA's ability to make maximum use of its resources to provide a full continuum of acute and long-term care services, both institution- and community-based. This initiative has a threefold purpose: First, to provide the VA with increased flexibility to make available to eligible veterans certain noninstitutional forms of health care services; second, to improve the VA's health care system; and third, to improve the VA's planning process for the construction of VA medical facilities.

SUMMARY OF PROVISIONS

Mr. President, the five substantive provisions of the bill would:

First, direct the VA to establish a pilot program to furnish medical, rehabilitative, and social services as an alternative to nursing home care for eligible veterans who would otherwise receive nursing home care.

Second, make permanent the currently authorized halfway house pilot program for veterans with alcohol and drug dependence disabilities.

Third, provide the VA with the authority to conduct a pilot program to furnish community residential care to certain chronically mentally ill veterans.

Fourth, require the Administrator to delineate the responsibilities of the Office of the Inspector General and the Department of Medicine and Surgery with respect to the monitoring, evaluation, and conduct of VA quality assurance programs.

Fifth, establish a committee of health care experts to review the VA's criteria and methodology for sizing VA medical facilities.

ALTERNATIVE TO NURSING HOME CARE

Mr. President, section 2 of the bill I am introducing today would amend section 620 of title 38, relating to transfers for nursing home care, to require the VA to establish a pilot program to provide medical, rehabilitative, and social services as an alternative to nursing home care for certain eligible veterans who would otherwise receive care in a nursing home environment.

Most Government health care dollars, including VA resources, are allocated to institutional care. Nursing home care represents a substantial portion of these resources. The growing demand for nursing home care and the high cost of institutional long-term care services has increased incentives for both public and private sectors to seek alternatives to institutional care. Experts in geriatric care and gerontology at the 1983 VA-Harvard University Conference on Aging and the 1984 VA-American Health Planning Association Conference on long-term care supported increased efforts to develop alternatives to institutional care and to coordinate and maximize the use of already existing community-based services. The VA's August 1984 report, Caring for the Older Veteran, outlines a specific extended care strategy advocating an increase in certain noninstitutional services for elderly veterans.

Certain research on long-term care has demonstrated that by providing community-based services, institutionalization may be reduced and patient longevity, independence, and satisfaction may be enhanced. However, verification of these study results and further fine-tuning and improvements on study designs and methodology are necessary before any final conclusion can be made about the advantages and cost-effectiveness of noninstitutional alternatives to nursing home care for the elderly.

The pilot program would serve two primary purposes: First, to increase the availability of cost effective long-term care options for elderly veterans; and second, to assess the feasibility, medical advantages and cost effectiveness of providing community-based services instead of nursing home care to certain veterans. This pilot program would address the following specific questions to what extent can providing community-based services for certain elderly persons in lieu of nursing home care: First, improve the quality of care; second, result in the provision of more appropriate kinds of care; third, reduce nursing home admission rates; fourth, lower the number of hospital days; fifth, reduce mortality rates; and sixth, reduce long-term care costs. The result of the evaluation of the program would contribute to the scientific knowledge base relating to noninstitutional services.

This provision also requires the Administrator to place special emphasis on and target services to veterans who are catastrophically disabled. Such veterans sometimes are prevented, due to the catastrophic nature of their disabilities, from residing in the community because of a lack of access to medical, rehabilitative or social services other than nursing home care.

In addition to medical and rehabilitative services, such as hospital-based home care and adult day health care services, the VA would have the authority to furnish social services to veterans participating in the program. For the purposes of the program, social services would be defined to include services to aid those elderly veterans or catastrophically disabled veterans in performing necessary activities of daily living. Such in-home and community-based services would include home health services, personal care services, home-delivered meals, and respite care.

ALCOHOLISM AND DRUG DEPENDENCE TREATMENT

Mr. President, section 3 of my proposal would provide the VA with a permanent authority to contract with private sector halfway house programs for veterans with alcohol or drug dependence or abuse disabilities and require the VA to strengthen its management of the halfway house program.

Each year approximately 100,000 veterans are treated for alcohol-related disorders in the VA's 102 alcohol treatment units and other programs. According to 1980 VA statistics, alcoholism-related disorders are the second largest category of diagnoses, next to heart disease, of patients discharged from VA hospitals. Approximately 38 percent of hospitalized Vietnam-era veterans were being treated for alcohol-related disorders.

Public Law 96-22, the Veterans' Health Care Amendments of 1979, established a 5-year pilot program for the treatment and rehabilitation of veterans with alcohol or drug dependence disabilities and provided the VA with specific authority to contract with halfway houses and other community-based treatment facilities for this purpose. It was the committee's intent to support the use of different modes of medically advantageous and cost-effective care for veterans with these disorders. Halfway house care is intended to be tailored to individual special needs, and is delivered in an unrestrictive environment. The primary goal of a halfway house is to provide veterans with a partially structured living and therapeutic environment as a transition from a total care environment to independent living in the community. It is estimated that 89 VA medical centers will have contracted with 303 halfway houses to provide care to 6,000 veterans in fiscal year 1985 at an average cost of approximately $20 per day. Estimated fiscal year 1985 program expenditures are expected to be $8.1 million.

During the 2d session of the 98th Congress, the committee examined the pilot program, but deferred action until this year to provide the House Veterans' Affairs Committee with the opportunity to review the program. At that time, the VA supported a 3-year extension of the program and stated that the program is therapeutically beneficial and cost-effective. However, an inspector general audit, released in November 1984, found that management improvements are needed to provide more effective monitoring and control over contractor services and billings. Providing permanent authority would be contingent upon the implementation of such improvements. Permanent authority would enable the VA to incorporate these services into the long-term planning and budget processes along with other permanent health care programs. Because the pilot program will expire at the end of this fiscal year, it is the appropriate time for the Congress to address the future of this important program.

COMMUNITY RESIDENTIAL CARE

Mr. President, section 4 of the bill would amend 630 of title 38, United States Code, relating to community residential care, to provide the VA with the authority to conduct a pilot program to contract for community residential care for certain chronically mentally ill veterans. This pilot program would be designed to provide more appropriate care for certain chronically mentally ill veterans for whom long-term institutional care is unnecessary and inappropriate.

A community residential care facility is a facility that provides room and board and limited personal care and supervision for residents who, because of health or mental health difficulties, are unable to live independently in the community. In 1983, Public Law 98-160 provided the VA with a limited authority to refer veterans to community residential homes and to monitor the homes receiving VA referrals.

Approximately 10 percent of the VA's long-term care psychiatric population are not referred to these homes for certain reasons, including an inability to defray the cost of residential care, and instead remain inappropriately institutionalized in VA medical facilities.

The American Psychiatric Association has determined that certain chronically mentally ill persons for whom institutionalization is not appropriate would be able to make a successful transition into the community provided that certain alternative services would be made available. Appropriate medication; stable financial support; supportive and appropriate community living arrangements; comprehensive medical, psychiatric, and rehabilitative follow-up services; crisis intervention services; and a designated case manager or management system responsible for administering and overseeing the individual's care are among these major requirements.

By providing the VA with an additional authority on a pilot program basis, the VA would be able to play a leadership role and use its integrated and comprehensive health care system to promote a successful community-based program for the chronically mentally ill. The VA's psychiatric day treatment and hospital-based home care programs would provide useful supportive and followup services to ensure its success.

QUALITY ASSURANCE

Mr. President, section 5 of this initiative would add a new subchapter to title 38 to: first, establish VA quality assurance programs as a statutory priority; second, clarify the role and promote the independence of the IG with respect to monitoring VA quality assurance programs; third, state that sufficient resources be allocated to adequately implement VA quality assurance programs; and fourth, improve Congress' ability to monitor VA quality assurance efforts.

Mr. President, the committee held a hearing on June 6, 1984, on the VA's quality assurance programs, including the roles of the inspector general and the medical inspector in monitoring such efforts. Certain questions about the inspector general's monitoring activities and the Department of Medicine and Surgery's specific programs were raised at that time and since then by the General Accounting Office as a result of its review of these important programs. This provision is intended to require the VA to clarify certain areas of major concern.

Since that time, the new Chief Medical Director, Dr. John Ditzler, has stated that quality assurance is a major priority and that he intends to modify existing quality assurance programs and initiate several new quality assurance efforts. I am highly supportive of Dr. Ditzler's initiatives and look forward to the results of his endeavors. I believe those provisions outlined above are general in nature and scope and consistent with the views of the Chief Medical Director and the quality assurance programs of the Department of Medicine and Surgery. These provisions would address the concerns of the committee while, at the same time providing the VA with the flexibility to continue to make its own determinations about the most effective ways to monitor the quality of care provided by the VA and develop and implement any new efforts in this area.

VETERANS' ADMINISTRATION MEDICAL FACILITY PLANNING

Mr. President, section 6 of the bill would establish a committee of VA and non-VA experts to: First, review the criteria for sizing VA medical facilities and services and the method for determining the criteria; and second, make any recommendations for necessary modifications in the criteria and process.

After reviewing agency information about and explanations of the assumptions, processes, and justifications for the medical facility construction projects for which the Veterans' Administration requests funding each year, I am very concerned about current policies and procedures used for determining the need for and size of the facilities proposed for construction. The VA bases its planning on the demographics of the entire veteran population in the area to be served as well as the historical utilization of VA facilities by these veterans. In light of the large potential demand for care from service-connected disabled and other priority groups within the fast-growing population of older veterans during a time of diminishing resources, I believe it is essential that the implications of current practice be evaluated.

Last year, in its resolution approving VA construction projects for fiscal year 1985, the committee stated its intention that the VA reevaluate its policies and methods for determining the size of VA medical facilities. No action was taken in response to this request. I believe it is important that certain factors, such as the relative statutory eligibility priorities, the impact of diagnosis-related groups [DRG's], the availability of community beds, the development and use of noninstitutional forms of care, and other factors be taken into account. The views of VA and non-VA experts in the fields of health care policy, planning and clinical practice and experts in medical facility construction would promote a comprehensive reevaluation of current sizing methodology and make recommendation to the VA for improvements in the current system.

[29]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

June 11, 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 876, 99th Congress, a bill "To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health care programs." VA opposes enactment of this bill.

S. 876 contains five distinct provisions. Section 2 of the bill would require VA to conduct a pilot program to furnish eligible veterans with medical and social services which would obviate the need for nursing home care. VA opposes this provision. Section 3 would extend, without limit, the VA's authority to contract for care, treatment and rehabilitation services in halfway houses and other facilities for veterans suffering from alcohol or drug dependence or abuse disabilities. VA favors a three-year extension of this authority, but we oppose this provision which would permanently authorize the program. Section 4 would require VA to conduct a pilot program to furnish, by contract, community residential care to chronically mentally ill veterans. VA opposes this provision. Section 5 would mandate that the Administrator establish and conduct a medical quality assurance program. VA opposes this provision because an excellent quality assurance program now exists. Section 6 would establish an advisory committee to make recommendations to the Administrator on medical facility planning. VA opposes this provision.

Section 2 of the bill would require VA to conduct a three-year pilot program in five geographic areas to furnish eligible veterans with medical, rehabilitation, and social services which would obviate the need for nursing home care. The program would commence on January 1, 1986. The bill contemplates that VA would provide these services by contract with public and private providers where available, or if that were not feasible, the VA could directly provide health related and supportive services. Veterans eligible to receive services would be those who would otherwise be receiving care in community nursing homes and who, as a result, would be able to reside at home. The measure calls for VA, in administering the program, to give priority to veterans over 65 years of age and those who are catastrophically disabled. Under the proposal, the cost of carrying out this pilot program in any fiscal year could not exceed 60 percent of the cost that the VA would have incurred if we had instead furnished community nursing home care to the participating veterans.

Congress provided, in 38 U.S.C. § 4101, that "[the] primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service." That mandate has generally been viewed as contemplating that VA will provide veterans with all needed medical services, either in VA operated facilities or, where necessary, in facilities for which the VA contracts. This mandate clearly excludes the provision of nonmedical social or supportive services which this proposal contemplates. Providing such VA assistance as homemaker or chore services, as proposed, would in part duplicate the assistance for which the basic aid and attendance allowances are currently paid to many veterans under 38 U.S.C. § 314(r)(1). Basic aid and attendance allowances are paid to eligible veterans so they may obtain nonprofessional help to meet such basic needs as feeding, washing and dressing themselves. Moreover, in many communities these services are already available to those who would otherwise need nursing home care. Provision of these services by the VA directly or under contract as contemplated by the law would duplicate these services.

Nevertheless, VA favors the basic concept of developing alternatives to institutional care. For example, we have submitted draft legislation to Congress which would authorize VA to conduct a three-year pilot test of "respite care." Under this proposal, VA would be authorized to furnish care at a limited number of facilities to chronically ill veterans who have the highest claim to VA care--service-connected disabled veterans--who have been receiving hospital based home care. The purpose of this proposal is to give brief, planned periods of respite to members of the veteran's household who would otherwise be rendering care in the home. This pilot program would provide a basis for our evaluating the efficacy of the "respite care" concept in avoiding or delaying the need for prolonged institutionalization and its potential for cost avoidance. The respite care pilot program would only require use of existing VA funds and would be targeted at the service-disabled veteran. Under our proposal, respite care would be furnished in existing operating beds with placements based on local needs assessments and resource availability.

We, of course, have several other programs, such as the adult day health care program and the hospital based home care program, which have long been recognized as providing important alternatives to institutional care. The VA also has broad authority already to conduct an evaluation of its noninstitutional treatment programs. Accordingly, we see no need for this provision and view the provision as unduly prescriptive in directing the scope and operation of the pilot program. In many respects, the requirements of section 2 are so specific that they would deprive VA of the latitude needed to derive real benefit from any such pilot program.

In addition, we do not favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources.

We estimate the cost of this pilot program to be $3.1 million for each of the next five fiscal years for a total five-year cost of $15.5 million.

Section 3 of the bill would extend without limitation the VA's authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. The existing authority for VA to operate this program expires on September 30, 1985. We strongly support extension of VA's authority to operate this program, but we do not at this time support making the authority permanent. We recommend that the program be extended for three years and we have submitted legislation to extend the authority through Fiscal Year 1988.

Since April 1980, the VA has operated a program authorized by Public Law 96-22 under which certain veterans suffering from alcohol and drug dependence have been provided treatment and rehabilitation in community contract facilities such as halfway houses. In authorizing its establishment, Congress called for VA to plan and operate a pilot program so as to demonstrate both the medical advantages and cost-effectiveness of this care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program. The required study indicated that those patients who were placed under this program were, on the whole, least able to cope in society.

VA prides itself on the quality of our substance abuse programs. Nevertheless, our study tends to show that, for approximately six to eight percent of VA patients admitted for substance dependence or abuse disabilities who are essentially alienated from society, many without family support and with no job in the community, contract halfway house care with its peer setting can greatly help reentry into the community and acquisition of self-help and job skills. This six to eight percent minority tends to successfully reenter the job market and place in the community better from halfway house care than from VA hospitals. We have found that the halfway house provides more definitive rehabilitation of recovery resistant cases requiring continued residential support and extensive work on self-help skills. It also offers economic advantages of shortening the total VA hospital-bed days by providing treatment and rehabilitation in a lower cost residential environment.

As of the end of FY 1984, 83 VA medical centers had contracts with 297 non-VA community based programs, and 16,685 veterans had been outplaced for treatment in these contracted facilities. The program evaluation study revealed strongly encouraging followup measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse prone veterans to warrant continued authorization for this program.

Section 3, however, would also require that the Administrator very closely monitor the operation of the program, collect an inordinate amount of statistical data for each and every contract facility, and annually report this data to the Congress. Specifically, VA would be required to collect data for each contract facility (there are 309 presently) on the level of success, rate of successful rehabilitation, the rate of readmission, the ability of the program to aid veterans in transition back to the community, the average cost per veteran, and the appropriateness of such cost when contrasted with costs in other community based programs.

We have no objection to providing Congress a report in light of the further experience we gain with the drug and alcohol halfway house treatment program aimed at assessing the continued usefulness of the program and determining if permanent extension of the program would be warranted. We object, however, to the requirement of the bill that we collect very specific and detailed data for each contract facility, aggregate it in Central Office, and report it all to the Congress. First, such data can be very misleading and not very useful since the number of veterans being treated in any given facility is generally not large enough to make a statistically significant assessment of the program. For example, if only two veterans are being treated in a given facility, and only one is successfully rehabilitated, those data suggest a 50% failure rate. In fact, the facility may have a better success rate when all patients are considered, both veterans and nonveterans. Moreover, we must object in general to the imposition of voluminous data collection and reporting requirements. Thus, we object to the provisions mandating that we collect, aggregate, and report statistics which may be of questionable validity.

We estimate the cost of continued operation of the program and of meeting the reporting requirements of the provision to be $6.4 million in each of the next five fiscal years for a total five-year cost of $32 million.

Section 4 of the bill would amend section 630 of title 38, United States Code, to mandate the establishment of a three-year community residential care pilot program for chronically mentally ill veterans. The bill would require the establishment of a program, conducted in five geographic areas, under which VA would contract for "care" to be furnished in community residential facilities. The measure would limit VA placements into such program to chronically mentally ill veterans who, but for receiving care in a community residential facility, would otherwise receive VA inpatient care and by virtue of participation in the program eventually would be able to reside at home. The bill would mandate that the program involve the use of VA psychiatric day treatment and hospital based home care programs and that administering facilities employ "unified case management services."

Section 4 of the bill appears to simply expand the VA's existing Community Residential Care Program (CRC), by allowing VA, on a pilot program basis, to pay for the cost of residential care for one group of veteran patients, the chronically mentally ill patients. Enacting such a measure would seriously damage the Community Residential Care Program, and, accordingly, we cannot support the proposal.

Under the existing Community Residential Care Program authorized by 38 U.S.C. § 630, VA, in essence, inspects and accredits residential care facilities, and refers patients to those facilities. VA does not, however, pay for this nonmedical residential "care". The fact that the veteran rather than the VA, pays those costs is in keeping with the general statutory mandate that the Department of Medicine and Surgery provide veterans with all necessary hospital and medical services, but not with nonmedical social or supportive services, as discussed in our comments on section 2 of this bill. That section would establish a pilot program to be an alternative to nursing home care and it would also involve provision of supportive services. We reiterate our earlier comments that other veterans' benefit programs, and other programs in the community, should be the principal mechanisms by which nonmedical support services are provided to veterans.

We estimate the cost of this pilot program to be $9.4 million in fiscal year 1986, and $39.2 million for the three-year life of the program.

Section 5 of the bill would mandate that the Administrator establish and conduct a comprehensive medical quality assurance program to monitor the quality of health care furnished by the VA. Under the proposal, the Department of Medicine and Surgery would conduct the quality assurance program and the Office of the Inspector General would be charged with monitoring the overall operation of the program. Given the VA's record of performance in this area, we see no need for legislation such as section 5.

We in the VA attach great importance to the quality of care provided to our veteran patients. It is our belief that any objective evaluation of the quality of care available in the VA system would lead one to conclude that eligible veterans can avail themselves of service in the VA confident that such service is safe, effective, and professionally competent. To assure that fact, we are committed to the maintenance and continued improvement of an effective medical quality assurance program, and require that a comprehensive peer review based program exist in every VA medical facility. VA's program is mandated by, and governed by regulations which are formally published at 38 C.F.R. §§ 17.500-17.540. The primary elements of the VA quality assurance program, known as the Health Services Review Organization (HSRO), generally encompass the measures which the Joint Commission on the Accreditation of Hospitals (JCAH) requires for a facility to be accredited. As you know, it is the policy of the VA that all medical facilities in our system comply with the accreditation requirements of the JCAH. Additionally, VA facilities are monitored by, and often accredited by, numerous other federal regulatory agencies, professional associations, and accrediting bodies including the Nuclear Regulatory Commission, the American Association of Blood Banks, and the College of American Pathologists, to name but a few.

There are numerous other mechanisms to assure that quality care is provided in VA health care facilities. Many of our medical centers are affiliated with medical schools, giving patients the benefit of that added resource. Many advisory boards and committees monitor various aspects of VA health care. Additionally, the Congress, both directly and through the GAO, regularly audits and reviews clinical programs for effectiveness and efficiency. Finally, we are currently implementing a Medical District based peer review program which will add another dimension to the quality assurance system. Computer assisted analyses of medical records and other existing and planned data bases will enable groups of specially selected VA physicians in each Medical District to monitor clinical activities at each facility, making judgments of quality based on specially developed standards and criteria, forwarding essential feedback to colleagues who are determined to keep pace with constantly improving standards of care.

The proposal would require that the Administrator delineate the responsibilities of the Office of the Inspector General (IG) and the Department of Medicine and Surgery (DM&S) with respect to monitoring, evaluation, and conduct of the VA's quality assurance program. We believe those respective roles have been well established under the Administrator's existing authority to delineate those responsibilities. As stated above, existing regulations, which were established by the Administrator, now mandate that the conduct of a program to monitor and evaluate the quality of care is a function to be performed by health care professionals in DM&S. It is also clearly the function of the Inspector General's office, as part of the auditing function vested in that office by the Inspector General Act, to make certain that a quality assurance program exists, and that the required procedures in that program are being correctly followed.

The bill would also direct that the Administrator allocate to the Inspector General necessary resources and personnel with appropriate qualifications necessary to review quality assurance programs. Resources are, and should continue to be, allocated in the normal budgetary process. We do not believe there has been a problem with allocation of resources to the Inspector General. The Inspector General Act grants authority to the IG to appoint personnel, including those with special qualifications as deemed necessary. That function is now being carried out by the IG without problems, and we do not believe a provision directing the Administrator to allocate personnel to the IG is necessary or appropriate, particularly when it could be construed as redundant vis a vis the Inspector General Act.

We also oppose the provision of section 5 which would mandate that the Administrator allocate sufficient travel funds to enable the Department of Medicine and Surgery to carry out its quality assurance function. Travel funds are, and should continue to be, allocated in the normal budgeting process. The effect of this provision would be, in essence to state in law that quality assurance activities have a greater need for travel dollars than all other DM&S activities requiring travel, and that already scarce travel funds must be allocated to that program regardless of other needs. We submit that such a provision is potentially deleterious.

The bill would also require that DM&S establish mortality and morbidity rate norms for all surgical programs in the VA, and then collect data on actual mortality and morbidity rates to compare with the expected rates. Additionally, the bill would require that data be collected regarding factors which would affect such rates, including characteristics of the patient population, the level of risk involved in the procedure based upon patient age, the kind of illness involved, and the severity of the illness. Under the bill, the Chief Medical Director would be required to contrast mortality and morbidity rates for "each surgery program" with the norms, and determine if deficiencies in the quality of care exist. The Inspector General would be required to review and report to the Congress on the comparison between actual rates and the mortality and morbidity norms.

The language of this provision, and accordingly the task imposed on VA, is unclear. The bill would have VA focus a major part of its quality assurance program on mortality and morbidity for each surgery program including, but not limited to, each cardiac surgery program. The term "surgery program" does not have widespread use in the VA. We do have designated "surgery programs" in three areas, cardiac surgery, renal transplant surgery, and heart transplant surgery. All other surgical procedures are carried out by specialty, e.g. thoracic surgery or urological surgery. If the bill is intended to impose the requirements pertaining to mortality and morbidity only on the three designated programs, the task could perhaps be technically accomplished without undue difficulty. On the other hand, if the intent of the bill is that mortality and morbidity rate norms be established for every surgical procedure, and data be collected on every procedure performed in every VA facility, the task would be monumental.

If we assume the bill requires establishment of norms, and collection of mortality and morbidity rates for all surgical procedures, we must be prepared to undertake an extremely costly and time consuming effort which would produce results which would be of very questionable value. Contrasting mortality and morbidity rates with rate norms is not a definitive method for determining quality of care. Many factors affect mortality and morbidity statistics such as age, economic status, health status, and patient referral patterns. Only qualified professionals have the training to evaluate those factors. Weighing the uncertain benefits of this proposal against the extraordinary costs it would impose, we urge the Committee to reject it. We believe other more conventional quality assurance mechanisms now in existence can make better use of surgical mortality and morbidity data. For example, physicians in VA hospitals, as part of the existing quality assurance program, conduct mortality/morbidity conferences. Such conferences are but one mechanism in the overall VA quality assurance program. The physicians meet, on a periodic basis, to review mortality and morbidity for surgical procedures. Typically, the conference might review a sampling of the records of all patients who underwent a specific surgical procedure during a specific time period. Such reviews, conducted by physicians who understand the meaning of mortality and morbidity data, and who are best able to assess that data, are a far more cost-effective and useful method for reviewing mortality and morbidity than the method proposed in this bill.

Finally, the bill would require that annually, the Inspector General's office should review the actual mortality and morbidity rates, contrast those rates with the established norms, and report the results of the review to the Congress. The Inspector General's office now performs cyclical audits of all VA medical centers at least once every three years. As part of such audits, that office would, if this bill were enacted, review mortality and morbidity statistics and contrast them with the established norms. Generally, this would be done as a sampling to make certain that the quality assurance mechanism is being conducted. However, we strongly oppose this provision if it is intended that the Inspector General annually review all morbidity and mortality rates for all procedures in all VA facilities, and then report the results to the Congress. Such a task would be an extraordinary effort in terms of cost and time, especially since the utility of the effort would be so questionable. We again reiterate that quality assurance should be a normal function of the medical staff, as it now is in the VA. It should not be converted into a mechanism used mechanically to attempt a centralized oversight function.

We estimate the cost of this proposal to be $7.4 million in each of the next five fiscal years for a total five-year cost of $37 million.

Section 6 of the bill would require the Administrator to establish an Advisory Committee on Veterans' Administration Facility Planning, consisting of members of the public including individuals with expertise in pertinent health care policy and planning, clinical practice, and medical facility construction and veterans' representatives. The Secretaries of Defense and Health and Human Services and the VA's Chief Medical Director would be ex officio members of the Advisory Committee. The committee would be charged with reviewing and evaluating the VA's criteria for sizing VA medical facilities including methods for determining such criteria. In that connection, the committee would be required to evaluate access by veterans to the VA health care system, and they would develop recommendations for modification of sizing criteria. Annually, the committee would report to the Administrator who would in turn transmit the report with comments and recommendations to the Committees on Veterans' Affairs.

We oppose this provision. The establishment of an advisory committee is but one of several possible vehicles for an agency to obtain advice or expertise from outside the Government. We see no justification or need at this time for reliance on this particular advisory vehicle. Its work would be duplicative of major efforts taken by the Agency, and its establishment is unnecessary. We presently use a bed-sizing model developed jointly by VA and GAO under a congressional mandate, to "size" VA-planned medical facilities. The model is considered a state-of-the-art methodology and is constantly being evaluated and refined as appropriate. VA staff are assigned to VAMC Gainesville to work in conjunction with the University of Florida to improve the model and to make adjustments to the model to incorporate new policy developments such as the VA resource allocation methodology. There is a standing advisory group of experts on operations research, modeling and health care from other federal agencies and from the academic community who provide consultation to the project staff.

Thus the purpose this provision is intended to accomplish is already being met. We estimate the cost of the advisory committee would be insignificant.

We estimate the costs of the whole bill to be $26.4 million for fiscal year 1986 and $124 million for five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez Jr. Deputy Administrator • For

HARRY N. WALTERS
Administrator

II

99TH CONGRESS
1ST SESSION

S. 1007

To amend title 38, United States Code, to direct the Administrator of Veterans' Affairs to develop and carry out a pilot program to determine the most cost effective methods of acquiring medical facilities to meet the needs of the Veterans' Administration and otherwise to promote additional health care for eligible veterans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 25 (legislative day, APRIL 15), 1985

Mr. BOSCHWITZ (for himself and Mr. DENTON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to direct the Administrator of Veterans' Affairs to develop and carry out a pilot program to determine the most cost effective methods of acquiring medical facilities to meet the needs of the Veterans' Administration and otherwise to promote additional health care for eligible veterans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Health Care Promotion Act of 1985".

SEC. 2. Section 5002 of title 38, United States Code, is amended by adding at the end thereof the following new subsection:

"(d)(1) In developing plans for a new or replacement medical facility, the Administrator shall give first consideration to leasing or purchasing any existing medical facility that satisfies the requirements of paragraph (2) of this subsection.

"(2) A medical facility satisfies the requirements of this paragraph if—

"(A) the facility meets the needs of the Veterans' Administration or is adaptable to meet such needs at a cost that does not exceed the cost of construction of a medical facility to meet such needs; and

"(B) the cost of operating the facility (after adaptation, if necessary) is not expected to exceed the cost of operating a new medical facility.".

SEC. 3. (a) For the purposes of this section, the term "medical facility" has the same meaning as provided in section 5001(3) of title 38, United States Code.

(b)(1) The Administrator of Veterans' Affairs shall carry out a pilot program to determine the most cost-effective method or methods of acquiring medical facilities for the Veterans' Administration. Under the pilot program, the Administrator shall acquire medical facilities using the methods set out in subsection (c).

(2) Not later than January 1, 1987, the Administrator shall enter into the contracts required by subsection (c) to carry out the pilot program. The Administrator shall carry out the program for such period, ending not less than 5 years after such date, as the Administrator determines to be appropriate.

(c)(1) The Administrator of Veterans' Affairs shall enter into a contract with an appropriate entity to construct and operate a nursing home for the Veterans' Administration. Under the contract, the Veterans' Administration shall furnish the funds for construction of the nursing home. The contract shall provide that the contractor shall operate the nursing home for 5 years after completing the construction and that the Administrator may renew the contract for an additional term not to exceed 5 years. The contract shall include a provision that the Veterans' Administration shall refer a sufficient number of eligible veterans who require nursing home care to the nursing home to assure an 80 percent occupancy rate for the nursing home for the term of the contract. All rights, title, and interest in the nursing home constructed under a contract entered into pursuant to this paragraph shall vest in the United States.

(2) The Administrator shall enter into a contract with an appropriate entity to plan for, design, and construct a medical facility for the Veterans' Administration and to lease or sell the facility to the Veterans' Administration, as the Administrator may direct. The Veterans' Administration shall operate the medical facility using Veterans' Administration employees.

(3)(A) The Administrator shall acquire two existing medical facilities as provided in subparagraph (B). The Veterans' Administration shall operate the medical facilities using Veterans' Administration employees.

(B) In carrying out subparagraph (A), the Administrator shall—

(i) purchase one medical facility that is located in an urban area and that is suitable for furnishing both hospital and nursing home services; and

(ii) lease one medical facility that is located in an urban area.

(d) The Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the administration of the pilot program and a final report promptly after the termination of the pilot program.

SEC. 4. Not later than 90 days after the date of enactment of this Act, the Administrator of Veterans' Affairs shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on (1) the extent to which the Veterans' Administration furnishes respite care to elderly veterans and to disabled veterans and (2) the Veterans' Administration plans for furnishing such care to such veterans in the future. The Administrator shall include in the report an estimate of cost savings likely to result from increasing the allocation of Veterans' Administration resources to respite care and other adult day health care and decreasing the allocation of such resources to long-term institutional care.

SEC. 5. (a) Not later than 90 days after the date of enactment of this Act, the Administrator of Veterans' Affairs shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an estimate of the cost of increasing the number of community-based nursing home beds available to the Veterans' Administration by 50 percent and an estimate of the cost of increasing the number of community-based nursing home beds available to the Veterans' Administration by 75 percent. The estimates shall specify the cost savings likely to result from reduced construction of medical facilities for the Veterans' Administration and a comparison of the cost per patient per day for care furnished in medical facilities owned by the United States and operated by the Veterans' Administration and the cost per patient per day for care furnished in other medical facilities under the jurisdiction of the Administrator.

(b) The Administrator of Veterans' Affairs is encouraged to place, through increased use of his authority to contract for medical facilities, as many eligible veterans as practicable in nursing homes located in the veterans' communities in the case of eligible veterans residing in areas other than urban areas.

SEC. 6. (a) The Administrator of Veterans' Affairs shall use not more than $25,000,000 of the working reserve funds available to the Veterans' Administration for fiscal year 1986 to purchase an urban medical facility for the purpose of carrying out section 3(c)(3)(B)(i).

(b) The President shall include in the budget submitted to the Congress under section 1105(a) of title 31, United States Code, for fiscal year 1987, a statement of the estimated expenditures and proposed appropriations necessary to carry out the pilot program required by section 3 in such fiscal year. The statement shall include the estimated expenditures and proposed appropriations necessary—

(1) to acquire medical facilities as provided in section 3(b) (other than estimated expenditures for which working reserve funds are required to be used as provided in subsection (a) of this section) and to renovate such facilities, if necessary; and

(2) to pay the personnel and other costs of operating the facilities.

(c) The Administrator shall achieve savings in the costs of operating medical facilities under the jurisdiction of the Administrator during fiscal year 1987 in a total amount sufficient to offset the personnel and other operating costs referred to in clause (2) of the second sentence of subsection (b). The Administrator shall achieve the cost savings by reallocating resources of the Veterans' Administration to the medical facilities referred to in subsection (b) from other medical facilities under the jurisdiction of the Administrator that have a surplus of beds, are underutilized, or are converted to perform new missions.

[From the Congressional Record, Vol. 131, No. 50, pp. S4758-S4762--Senate, April 25, 1985]

S. 1007. A bill to amend title 38, United States Code, to direct the Administrator of Veterans' Affairs to develop and carry out a pilot program to determine the most cost-effective methods of acquiring medical facilities to meet the needs of the Veterans' Administration and otherwise to promote additional health care for eligible veterans, and for other purposes; to the Committee on Veterans' Affairs.

VETERANS' HEALTH CARE PROMOTION ACT

Mr. BOSCHWITZ. Mr. President, today, along with my good friend and colleague from Alabama, Senator DENTON, I am introducing the Veterans' Health Care Promotion Act of 1985.

The roots of this legislation are long-stretching back to nearly 1980 when I became involved in trying to provide funds for a replacement hospital for the aged and outdated Minneapolis Veterans Hospital.

Those battles with the VA over its constantly changing priority list, and the parallel battles with certain local groups over the lack of need for a replacement facility because local hospital beds were unused, laid the groundwork for my continuing interests in veterans health care and the VA's construction process.

Mr. President, since those days in 1980 the VA has spent $2.7 billion on the construction of new or replacement medical facilities. This year the administration's budget calls for an additional $2.5 billion over the next 3 years. And this is really just the tip of the iceberg. CBO projects that $400 million will be needed over the next 5 years just to meet the new construction needs for nursing homes. However, if the VA attempts to retain its current level of providing nursing home beds, the costs would go up an additional $200 million.

Currently the VA provides 40 percent of the veterans nursing home beds, the State Home Program provides 20 percent, and the remaining 40 percent are contracted on an individual basis to non-VA nursing homes.

And in addition to nursing home spending, CBO estimates that the funds needed for the replacement or modernization of existing VA hospitals could cost as much as $2.9 billion.

Unfortunately, the VA's construction process is three to five times as expensive as the private sector. This means that while we are doing what we can to see that the veterans of this country are getting the health care they deserve, we are clearly not getting as much bang out of the buck as we could. And in this budget cutting climate we have to stretch each dollar as wisely and as far as we can. That is why I decided to introduce my legislation. I feel that if we can cut costs in the construction area, we can provide more beds, serve more veterans, and provide better overall health care for this Nation's veterans.

I realize that at first blush some may see my bill as somewhat controversial, and perhaps as a first step of some sort toward dismantling the Veterans' Administration health care system. But it's clearly not either of these. In fact I believe my bill gives us a unique opportunity to strengthen the VA health care system.

Mr. President, everyone involved with veterans and the VA knows the crunch is coming. The demographics of the aging veteran have been published in every major media forum. The VA also, to its credit, has tried to address and plan for the influx of aging veterans.

If the VA is right and the demand for VA health care triples by the year 2000—with patient load leaping from 4.5 million today to over 12 million—then there will be a tremendous strain on both the VA and its budget. Clearly, we want to be in a position to provide VA health care for as many eligible veterans as we can.

Therefore, we must realize that in order to pay for the care we have promised the veteran, we must develop more cost-effective methods of providing it. But we must provide it in such a way that we don't jeopardize the commitments we have made to our veterans. And we must also recognize that the VA's costs will normally be somewhat higher than the private sector because of the type of patients it serves and the dedicated mission it has been given. However, it is clear Congress and the VA must look at the options and alternatives available.

That is what the bill Senator DENTON and I are introducing today is designed to do. First, get the VA to look at other ways to provide care before simply building a new expensive facility. Second, the bill sets up four pilot projects that will allow the VA, Congress, and the veterans of this country a chance to see how these options work.

Basically this legislation does three things.

First, it requires that the VA's first option when developing plans for new or replacement medical facilities shall be to consider leasing or purchasing existing community facilities. The VA has the authority now to lease or acquire existing facilities, but it has never used it for either hospitals or nursing homes.

Second, sets up a pilot program to look at four different scenarios. The first would be a privately built, privately run nursing homes that the VA would contract eligible veterans to in a 5-year agreement. Veterans in my State of Minnesota support such a pilot project located in Grand Rapids, MI. In this case, a veteran would like to build a nursing home facility for vets and then run it with his staff.

The second would be a nursing home that was privately planned, designed, and built that would then be leased to the VA and run by the VA. This nursing home would then revert to the private sector when no longer needed by the VA.

The third would require the VA to purchase an existing medical facility. It seems that a perfect opportunity to exercise this option is available in Mobile, AL, where the VA can acquire a hospital for $25 million, and in fact the purchase option has been looked at by the VA and the local community. In contrast, the replacement Minneapolis hospital I fought so hard and successfully to get funded cost over $200 million.

The fourth option would be for the VA to simply lease an existing facility.

Third, the bill also requires the VA to report on the potential cost savings of increasing the number of nursing home beds contracted to community facilities. As I mentioned earlier, the VA has a 40-percent share of the veteran nursing home beds, as do community contracts. The bill asks the VA to look at increasing the community share to 60 percent or 75 percent.

Mr. President, this provision was included in the bill primarily because of a survey I mailed to over 60,000 Minnesota vets last summer asking for their views on how Congress should fund the number of nursing home beds that will be needed by the year 2000. The results were somewhat startling with 73.4 percent of the respondents saying that the VA should not build more nursing homes. Overall, the results reemphasized my belief that veterans are concerned both about available health care and cost-effective care.

I ask unanimous consent that the results of this survey be included in the RECORD at this point.

There being no objection, the survey was ordered to be printed in the RECORD, as follows:

HEALTH CARE FOR THE AGING VET SURVEY RESULTS

(Based on results of 600 returned surveys)

SURVEY

I. How should nursing home sites be chosen? (Rank choices 1-4)

1. Number of Service-Connected Vets in an Area: 65 percent rank this as first or second choice.

2. Number of Veterans in Area Unable to Pay: 40.2 percent rank this as first or second choice.

3. Number of Vets as Percent of Population in Area: 36.7 percent pick as their first choice, but 53 percent have listed as third or last choice.

4. Distance From Existing Facility: 54 percent rank as third or last choice.

II. Should the VA build more nursing homes? 26.6 percent say Yes; 73.4 percent say No.

III. How should we "find" more nursing home beds?

1. Leasing Existing Facilities, Use VA Personnel: 71.4 percent chose as their first or second choice.

2. Leasing Wing of Existing Facility, Using VA personnel: 66.0 percent chose as first or second choice.

3. Use Community Facilities, Pay Per Diems: 45 percent chose as first or second choice.

4. Build More Nursing Homes: 65.8 percent chose as their last choice—only 24.3 percent chose as their first or second choice.

IV. Do you support contracting out of nursing home care? 64 percent said Yes; 27.2 percent said No; 8.7 percent didn't know.

Of those who responded 57 percent within 50 miles of an existing VA facility; 28.3 percent live more than 100 miles.

V. Should the VA devote more of its resources to programs like Adult Day Health Care—seeking to keep the vet out of a full-time facility?

Over 80 percent said that the VA should devote more of the resources.

Mr. BOSCHWITZ. Mr. President, I hope my colleagues will agree that the time is right to look at different ways to spend our VA construction money. The crunch is certainly coming. If we can get started now, maybe we can do more than just wring our hands when the time comes.

I also hope my colleagues will join me in working with the VA, veterans groups and the Veterans' Committee in working with this bill, perhaps improving it, and then seeing it made into law.

I ask unanimous consent that the text of the bill be entered in the RECORD at this time.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

* * * * * *

Mr. DENTON. Mr. President, I am pleased to join with my colleague from Minnesota, Senator BOSCHWITZ, to introduce legislation to provide for the "Veterans' Health Care Promotion Act of 1985." The legislation is particularly appropriate at a time when we are concerned about providing adequate medical care for our veterans, both nursing homes and hospitals, but face an increasing necessity to reduce the Federal budget.

For each of the 5 years that I have been a member of the Committee on Veterans Affairs, the VA has requested large sums of money to build new hospitals to serve our veterans. The costs of the new hospitals are substantial, and we see with some frequency the construction of large, modern, expensive facilities in localities where it is difficult to justify the size and the cost.

I have taken a quick look at the costs of recently activated VA hospital facilities, and I think that it is kind of interesting. For 10 hospitals activated between 1973 and 1984, ranging in size from 205 beds to 1,205 beds, the costs per bed of the total project, in 1984 dollars, ranged from a low of $95,000 to a high of $313,000. The average cost per bed for the 5,951 beds built with $1.117 million (1984 dollars) was about $188,000.

I must say, Mr. President, that I have not noticed any inclination on the part of the Veterans' Administration to deal with that problem by finding less expensive or more cost-effective ways to provide necessary new or replacement beds. Indeed, the VA takes pride in the fact that it has not in its history acquired existing hospitals—other than its initial taking over of existing military hospitals—and that it builds new facilities of the most modern and, I must say, most expensive kind.

Everyone who has looked at the problem says that if the VA is going to continue to add hospitals, it needs to find a less expensive way to do it. The Congressional Budget Office, the Office of Management and Budget, and the VA itself have all said that the VA may well have to, or should, consider the lease or purchase of existing hospital facilities. Yet I have yet to see any action from the VA to explore or implement that concept.

The same general situation applies to nursing homes, which are of increasing importance as our veterans population grows older. The demographics tell us that we do face a problem with the massive population of World War II veterans who are reaching the point where they will need increased access to both nursing home and hospital care.

The VA already has the authority to purchase or lease existing medical facilities, which includes nursing homes as well as hospitals, but has not yet done so, and has not shown an active interest in exploring the possibility. That is one reason that I believe that the pilot program provided by the bill will be of great value.

The problem has been brought home to me by a situation in my State that seems to provide an unexcelled opportunity.

As background, it is important to understand that the VA planning process for the medical district that includes Alabama, the Florida Panhandle, and southeastern Mississippi has for several years provided for the construction of a new VA hospital, in the 1990's, to serve the veterans located in the Florida Panhandle, south Alabama, and a small portion of Georgia. The new hospital is, however, only in the long-range plan, and the VA has not yet gotten to the point of including it in its actual construction plan.

We are, therefore, talking about an expensive new hospital to be built at some future time when costs will be higher and the budget tighter that it is now. In the meanwhile, an identified need goes unsatisfied, and the veterans and other interested parties can only hope that current plans ultimately come to fruition.

It is, nonetheless, clear that the VA has accepted the need for a new hospital in the region.

Last year, and by coincidence, a very fine private hospital in Mobile, AL—Providence Hospital—became available because its owners and operators, the Sisters of Mercy, are building a new hospital in a different part of town. They are not building a new hospital because there is anything wrong with the old one, large parts of which are new and all of which is well maintained. They are building because of a perception that their service mission required a different location.

The veterans in the area saw the availability of Providence as a boon to address a situation in which it was clear that the VA itself saw the need for a new hospital but in which that new hospital would be many years in the making and cost a great deal of money. They developed the view that the VA, the taxpayers, and the veterans would be better served if the VA acquired Providence as a VA facility rather than building a new hospital.

There were some additional considerations that were involved in the decision. Providence Hospital is relatively large, with 349 acute care beds, and has an adjacent 126-bed school of nursing which could be used for a veterans' nursing home. There are no nursing home beds currently available in south Alabama. The grounds are about 15.3 acres, with 1,000 paved parking spaces. There is a residence with space to house 13 employees. The hospital has the most modern facilities and equipment, all of which are available for purchase. In addition, the hospital could easily be a very good tertiary care facility because of its existing capabilities and the possibility of affiliating with a good medical school in Mobile. And the price is right, about $24 million.

I repeat, about $24 million. That is not much more than the cost for the design—just the design—of a new hospital now underway in a major city in another part of the country. As someone remarked the other day, this is the best deal around.

The veterans approached me with their idea. I confess that I was relatively cool to it at first because it looked too good to be true. Nonetheless, I asked the VA to take a look at the hospital to see whether, in physical terms, it would be usable.

The VA agreed to take a look at Providence, and did so with a professional team from the Office of Construction in the Department of Medicine and Surgery. Let me quote a couple of statements from the conclusions of its report, over the signature of the Director, Facility Planning Service, Department of Medicine and Surgery:

> The VA team concluded that the Providence Hospital is well maintained and in generally good condition. The newest construction is in excellent condition . . . It is the team's belief that if a programmatic determination were made to establish a VA medical center in Mobile, the Providence Hospital could be adapted to serve in this role. A detailed analysis would be needed to determine the cost of modifying Providence and thus the true costs of acquisition.

That's the VA's own people speaking, Mr. President. It struck me, and everyone else who has read the report, as a pretty good conclusion. What it meant, of course, was that there was nothing inherent to the hospital and its facilities that militated against its possible conversion to a VA facility.

In addition, the chairman of the Veterans' Affairs Committee in the other body asked one of his senior people to look at the situation. That look, by an experienced and knowledgeable individual, suggested that "the matter be further pursued with the Administrator of Veterans' Affairs," with some additional recommendations, and I quote in part:

> . . . the Administrator be urged to give serious consideration to the acquisition of Providence Hospital, Mobile, AL.

The report went on to say that if the VA wants to put a hospital in that region and does not want to use Providence, it should be made to show in detail why Providence is not suitable or economical, and to show that staffing and quality of care would be as easily done and as good elsewhere as it would be in Mobile.

That position seems pretty strong to me, and certainly suggests that the matter should be looked at fully and carefully.

I won't go into detail with all the other arguments for this particular way of addressing the needs of the veterans in that part of the country. I will say, however, that the merits of the case seem so compelling to me that I would support a close look at the situation no matter where it might be found, anywhere in the country.

Yet the VA cannot seem to get very interested in the problem. There are some reasons for that, although they do not seem to me to be compelling when one looks at the costs involved and the potential savings.

If we use an average cost per bed for a new hospital in 1984 dollars, which the VA has given as about $300,000 per bed in this location, a 225-bed new hospital to serve the veterans in the region would cost something like $67.5 million. I doubt that there are very many of us who do not expect that the cost would increase substantially, in both dollar and real terms, by the time that the VA gets around to building that hospital, if it gets around to it at all.

By contrast, Providence could be bought as is, and fully equipped, for something like $25 million. With 349 beds, the cost per bed would be $71,500. Even if we assume that it might cost, say, $15 million—and I seriously doubt that it would cost anything like that—to convert the facility to VA standards and usage patterns, the cost per bed is only $115,000, or about one-third of the estimated cost that we might expect for new construction. And there is a lot of other stuff that comes free for that price, such as a facility that would serve well as a nursing home.

In other words, we could save a minimum of $25 or $30 million over the total cost of new construction, get more beds and a lot of other things in the bargain, and have an operating hospital several years sooner. After all, it takes something like 4 to 8 years from initial funding to activation of a hospital.

I do not deny that there are costs involved in saving money in this instance. There would have to be readjustments in hospital service areas, the location in the region may not be ideal—although it is pretty good—and the VA would have to wrench itself out of its traditional pattern of providing hospitals only through new construction.

Nonetheless, the monetary savings would be substantial, and our veterans would benefit greatly. And that's what it is all about.

The bill, Mr. President, provides in section 3 for four pilot projects, each of a different nature and each innovative. One of those is the purchase of an existing urban medical facility that can furnish both hospital and nursing home services. Senator BOSCHWITZ and I had Providence Hospital in Mobile specifically in mind when we drafted that provision.

Mr. President, I believe that our veterans, our taxpayers, and our country will be well served by the bill that Senator BOSCHWITZ and I propose. I know that my colleague has encountered somewhat the same situation in his State as I have in mine, a situation in which there is an opportunity to provide service to veterans in an innovative way that promises reduced cost. I commend him for his initiative in drafting the bill, and I appreciate his courtesy and cooperation in working with me to develop it further.

Mr. President, I urge my colleagues to support the bill. I believe that the pilot program for which it provides will be successful, and that it will set us on a course that will benefit veterans in every State throughout our country. It will demonstrate that we can provide effective and efficient service to our veterans by the use of innovative approaches to facilities. Moreover, I believe that the VA will find the experience so congenial that it will take the initiative in further acquisition of facilities, whether nursing homes, hospitals, or replacements for current VA facilities when necessary.

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COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 12 1985

Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 1007, 99th Congress, a bill "To amend title 38, United States Code, to direct the Administrator of Veterans' Affairs to develop and carry out a pilot program to determine the most cost effective methods of acquiring medical facilities to meet the needs of the Veterans' Administration and otherwise to promote additional health care for eligible veterans, and for other purposes."

The major provisions of S. 1007 would require the following:

(1) that for new or replacement medical facilities, VA must generally give first consideration to leasing or buying an existing facility;

(2) that VA implement a pilot exercise involving the acquisition and operation of medical facilities through specified mechanisms and funding limitations to determine the most cost effective method of acquiring medical facilities; and

(3) that VA report to the Congress estimating the cost, and resultant savings due to decreased construction, of increasing the number of community nursing home beds available to the VA by 50% and 75% respectively.

As discussed in more detail below, we do not believe that implementation of the proposed pilot program represents an effective means of achieving the apparent desirable purposes sought. Accordingly, we oppose this measure.

Section 2 of the bill would amend 38 U.S.C. § 5002 to require the Administrator, when planning for a new or replacement medical facility, to give first consideration to leasing or purchasing an existing facility if such a facility exists, if it meets VA needs, and if it would be more cost effective to acquire and operate the facility than to construct a new one. VA now has the authority to acquire existing medical facilities by either purchase or lease. It is our view that if an existing facility meets VA needs in terms of location, size, condition, VA standards, susceptability to needed adaptation, and long term, life cycle cost-effectiveness, then such a facility should be either purchased or leased in lieu of construction of a new facility. Certainly, if those conditions were met, VA could and would, under existing law, give priority consideration to acquisition of the existing facility rather than construct a new one.

As presently worded, its enactment could have unintended effects. Mandating by statute that VA give first consideration to the purchase or lease of existing facilities could spark unwarranted pressures on the VA to acquire specific facilities and give rise to time-consuming challenges to VA determinations that a facility does or does not meet VA needs, that it could or could not be adapted or operated in a cost-effective manner, or that it is better than other existing facilities. Such challenges could result in delays or added costs in obtaining needed new VA health care facilities. Finally, therefore, we recommend deleting the word "first" and adding "consideration of other costs and factors which the Administrator finds are relevant."

Section 3 of the bill would mandate that VA undertake a pilot program aimed at determining the most cost-effective method of acquiring various types of health care facilities. Under the pilot program VA would be required to acquire and operate several medical facilities in different ways. First, VA would be required to enter into a contract with an appropriate entity for the construction and operation of a nursing home. VA would be responsible for paying all costs of construction and assuring the contractor an 80% occupancy rate. The bill calls for the contract to provide that the contractor operate the VA-owned facility for five years after construction, with provision for renewing the contract for up to five years.

Under section 3, VA would also be required to contract for planning, design, and construction of a second medical facility, which the contractor could then either lease or sell back to the VA. It would be operated by VA using VA employees. In contrast to the requirements regarding other facilities to be obtained under this program, the provision is not specific as to what type of medical facility should be constructed or where it should be located. Finally, the Administrator would be required to acquire two existing medical facilities, both of which must be located in urban areas. The first such facility must be purchased and must be suitable for furnishing both hospital and nursing home services. The second facility must be leased, but the provision is not specific with respect to the services and level of care it should provide.

The bill also sets funding limitations in section 6 on the implementation of the pilot program. It requires that the Administrator use up to $25 million of the VA's "working reserve funds" available in fiscal year 1986 to purchase an existing medical facility under the pilot program. Section 6 would also require that the President include in the fiscal year 1987 budget request, a statement of the expenditures needed to carry out the entire pilot program mandated by section 3 of the bill, and the proposed appropriations needed to fund the program. Finally, section 6 would mandate that the costs to pay personnel and other operating costs for the two existing facilities must be obtained through savings from reallocation of resources from other VA facilities that have surplus beds, are underutilized, or are converted to perform new missions.

VA opposes the pilot program proposed in sections 3 and 6 of the bill. The premise underlying the proposal for the pilot program would appear to be that VA can acquire new or replacement health care facilities of acceptable quality and sufficient to meet veteran needs more quickly, and at a lower cost than under existing methods. We do not believe the proposed pilot program offers a satisfactory methodology for testing that premise.

The pilot program proposes that VA acquire two facilities by simply contracting with an appropriate entity (we assume a private corporation) to plan, design, and construct the facilities. The notion underlying the bill assumes that if the entire matter were left to the private contractor, the facility would be able to begin operation more quickly and at less cost. We disagree. To ensure appropriate standards and functionality, the VA would have to provide the contractor, as we do now, with information regarding the kind of facility needed, its size, what services it should provide, where it should be located, and what quality standards would have to be met. In short, VA would still have to do the planning necessary to assure that the facility would most efficiently serve the needs of the population which will use it and meet VA standards for health care facility construction. Thus, VA must provide the contractor with detailed specifications and continue to coordinate through all phases of the project. It would be irresponsible to do otherwise. It is unclear that this process, which is essentially what we do now, would result in any significant savings of time or cost. The VA already contracts with the private sector for the design and construction of our facilities, based on VA standards, specifications and rigorous quality and cost controls throughout the course of such contracts.

One element of the pilot program also proposes that VA simply turn over the care of veterans to a private contractor. The contractor would build the facility to care for veterans, and then would operate it. Such a proposal runs counter to the longstanding congressionally mandated VA mission that eligible veterans be provided care in independent VA-operated health care facilities. It continues to be the policy of the VA that whenever possible, VA provide a complete hospital and medical service in VA-owned and operated facilities.

Specific provisions of section 3 are also very ambiguous, giving rise to major questions. For example, VA is directed in one instance to contract for construction and operation of a nursing home, and contractually, we must guarantee the contractor an 80% veteran occupancy rate. However, the bill does not specify how VA will pay operating costs. Is the contractor free to fill 20% of the beds with nonveterans at a pure profit to itself? Are we to pay a per diem for the veteran patients only? Are we to pay total operating costs including the costs for nonveteran patients? Section 3 also directs VA to contract for planning, design, and construction of a medical facility which the contractor will then lease or sell to the VA. VA now ordinarily contracts for the design and construction of facilities, but we do not lease or purchase them after we paid for construction. Is it intended that this particular facility be constructed on land owned by the contractor necessitating our purchase or lease after we have built it? Are the Davis-Bacon Act and other Federal requirements applicable to that construction?

As regards the pilot program overall, we believe the information which it would produce is unlikely to provide a meaningful basis for determining the most cost-effective means of acquiring medical facilities for VA. Each VA health care facility, be it a medical center, a nursing home, an outpatient clinic, or a domiciliary, is unique. Facilities vary significantly in size, mission, patient makeup, location and capability for delivering various types of services. For example, it would be unreasonable to gauge by the same indices a relatively small unaffiliated facility in a rural area, which provides a great deal of psychiatric care, with a large affiliated urban facility providing a full range of services. All of these variables affect the cost of the acquisition and operation of a facility and make it unrealistic to draw meaningful conclusions from the acquisition and operation of four different facilities that must necessarily be tailored to local demographics, the capabilities of other VA and Government facilities in the region, and the strengths and weaknesses of other medical facilities in the community.

We also object to the pilot program because it would direct that VA acquire medical facilities outside of normal planning processes and that contracts for acquisition be entered into by the unrealistically short deadline of January 1, 1987. VA uses a well developed process for determining what the mission of a facility should be, where it should be located, what its size should be, and whether it should be newly built, purchased, leased, or whether existing facilities should simply be enlarged or renovated. Section 3 would require VA to acquire and operate several health care facilities completely outside of this facility planning process.

We strongly believe it would be far more efficient and cost effective to use existing sources of information to estimate the costs of acquiring facilities in different ways than to carry out costly pilot test programs. VA has constructed various types of health care facilities in recent years. We could more easily and reliably compare relative costs if we could obtain accurate and complete cost data from the private sector, and use economic modeling techniques. Unfortunately, VA has been largely unsuccessful in its efforts to obtain cost data from private sector institutions. The General Accounting Office was similarly unsuccessful when it attempted last year to compare the cost of VA nursing homes to private sector nursing homes. Nonetheless, presuming the availability of objective, verified data, the same cost comparison results as intended by the pilot program could be achieved without a massive expenditure of public funds.

In addition to our objections to the pilot program itself, we strongly object to the provisions of section 6 of the bill which sets limits on its implementation. First, we do not believe it would be prudent to reduce the VA's existing working reserve fund by $25 million to acquire a hospital under the pilot program. The fund now contains approximately $27 million, and that amount might be less in fiscal year 1986. In any case, a $2 million remainder after the expenditure of $25 million would be grossly deficient to meet upcoming needs. Even more troublesome is the untested premise that VA can simply "reallocate resources" to provide the considerable monies required to pay the operating costs of facilities acquired under the pilot program. We strongly believe reallocation of resources among VA facilities should only be accomplished through normal VA planning processes. The funding needs for this pilot program should not dictate the reallocation of resources among VA facilities.

Section 4 would require VA to report on the extent to which it furnishes "respite care" and our plans for furnishing such care in the future. Although the bill does not define the term "respite care," we understand that term to mean institutionalizing chronically ill individuals for brief periods so as to provide family members a respite from the demands of home care. VA has no "respite care" program at this time. In light of the need for a specific statutory basis to establish such a program and our interest in testing the efficacy of furnishing respite care, we have submitted draft legislation to authorize VA to conduct a three-year pilot test for service-connected veterans. Section 4 of S. 1007, however, appears to be premised on the erroneous assumption that VA already has such authority and has developed plans for implementing it. In the absence of a statutory basis for VA to provide respite care, VA cannot provide the kind of definitive information contemplated in section 4. However, this type of information could be included in our proposed pilot test program.

Section 5 of the bill requires that within 90 days after enactment, VA must report to the Congress estimating the cost of increasing the number of community nursing home beds available for use by the VA by 50% and 75% respectively. The report must specify the cost savings likely to result from decreased construction of VA-owned nursing home beds as a result of increasing available community nursing home beds. It must also provide a comparison of the cost per patient day for care in VA-owned and operated nursing homes as opposed to care furnished in other VA facilities, presumably medical centers. Finally, section 5 encourages the Administrator to use contractual authority to provide care to as many veterans as is practicable in community nursing homes located in nonurban areas.

At this time, approximately 33% of VA nursing home care is actually provided in VA facilities, 39% is provided in community nursing homes, and 28% is provided in state homes. Although it is not clear, we assume that section 5 is intended to seek estimates of the costs involved if VA simply increased the percentage of VA patients receiving care in community nursing homes by 50% and 75% respectively. VA can provide cost estimates, but other factors should be considered to determine the feasibility of implementing such an increase, for example, location, supply, etc.

Honorable Frank H. Murkowski

Currently, the VA provides approximately 12% of all nursing home care now being furnished to the veteran population. More importantly, VA provides only approximately 2% of the nursing home care provided in this country, and only about 39% of that is provided in community nursing homes. Accordingly less than 1%, or less than one nursing home bed in every one hundred is paid for by the VA. Thus, we question the likelihood that VA demand for nursing home care would have any significant impact upon the supply of nursing homes in this country. A private nursing home proprietor is unlikely to build a new nursing home or increase the size of an existing home premised on a small increase in demand by the Veterans' Administration.

It should also be noted that the construction of new nursing home beds is dependent upon states granting certificates of need for additional beds. Currently, very few certificates are being issued in states throughout the country. The VA can exercise no control over this state process. Thus, we do not anticipate that if section 5 were enacted that VA could furnish much helpful data.

If amended as noted above, we would not oppose sections 2, 4, and 5 of the bill. The costs of implementing these sections would not be significant. However, we do oppose sections 3 and 6 of the bill. Costs for the pilot program could be determined only after decisions are made regarding the types of facilities which should be acquired, where they would be located, and what size they would be.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez J

HARRY N. WALTERS
Administrator

99TH CONGRESS
1ST SESSION

S. 1052

To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to carry out demonstration projects to furnish chiropractic services to certain veterans and to evaluate the cost effectiveness of furnishing such services to such veterans.

IN THE SENATE OF THE UNITED STATES

MAY 2 (legislative day, APRIL 15), 1985

Mr. THURMOND (for himself and Mr. DECONCINI) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to carry out demonstration projects to furnish chiropractic services to certain veterans and to evaluate the cost effectiveness of furnishing such services to such veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Chiropractic Services Demonstration Projects Act of 1985".

SEC. 2. (a) Section 601 of title 38, United States Code, is amended by adding at the end thereof the following new paragraph:

"(9) The term 'chiropractic services' means the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))) to correct a subluxation of the spine. For the purposes of this paragraph, such term does not include physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded.".

(b)(1) Subchapter III of chapter 17 of such title is amended by adding at the end thereof the following new section:

"§ 631. Chiropractic services demonstration projects

"(a) The Administrator shall conduct not less than five demonstration projects in five geographic regions of the United States during fiscal years 1986, 1987, and 1988—

"(1) to furnish chiropractic services to veterans eligible for medical services under this chapter; and

"(2) to evaluate the therapeutic benefits and the cost effectiveness of furnishing chiropractic services to such veterans.

In developing the demonstration projects, the Administrator shall consult with the Secretary of Defense regarding the demonstration projects carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note).

"(b) In carrying out the demonstration projects required by subsection (a) of this section, the Administrator shall enter into cooperative agreements with not less than five chiropractic colleges in five geographic regions of the United States—

"(1) to coordinate jointly the provision of chiropractic services to eligible veterans by chiropractors under the demonstration projects; and

"(2) to perform jointly clinical research and data collection regarding the therapeutic benefits and the cost effectiveness of furnishing chiropractic services to eligible veterans.

"(c)(1) The Administrator shall, under regulations which the Administrator shall prescribe, reimburse a veteran eligible for medical services under this chapter for the reasonable charge for chiropractic services furnished to the veteran under the demonstration projects required by subsection (a) of this section, for which such veteran has made payment, if—

"(A) such chiropractic services were for the treatment of a service-connected neuromusculoskeletal condition of the spine,

"(B) the veteran is a veteran who has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a twelve-month period prior to the provision of such chiropractic services, or

"(C) the veteran is a veteran described in section 612(f)(2) of this title who has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine,

to the extent that such veteran is not entitled to such chiropractic services or reimbursement for the expenses of such services under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

"(2) The Administrator may, in lieu of reimbursing a veteran for a reasonable charge for chiropractic services under paragraph (1) of this subsection, make payment of the reasonable charge for such chiropractic services directly to the chiropractor who furnished such services.

"(d)(1) The Administrator shall, in consultation with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, establish a schedule of reasonable charges for such services, which schedule shall be consistent with the reasonable charges allowed under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

"(2) The amount payable by the Administrator for chiropractic services furnished under demonstration projects required by subsection (a) of this section shall not exceed $600 in any twelve-month period in the case of any veteran.

"(e) The Administrator shall prescribe a limit on the amount payable to any chiropractic college in any fiscal year under a cooperative agreement entered into under subsection (b) of this section.

"(f) Notwithstanding any other provision of this title, total expenditures for chiropractic services reimbursed under this section shall not exceed $2,000,000 in any fiscal year.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 630 the following new item:

"631. Chiropractic services demonstration projects.".

SEC. 2. Not later than December 31 of each of the years 1986, 1987, and 1988, the Administrator of Veterans' Affairs shall prepare and submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the use made of the authority provided in the amendments made by the first section. Each such report shall include—

(1) the number of requests made by eligible veterans for reimbursement or payment for chiropractic services in the most recent fiscal year under demonstration projects carried out under section 631 of title

38, United States Code (as added by subsection (b) of the first section), and the number of such veterans who made such requests;

(2) the number of reimbursements or payments made by the Administrator of Veterans' Affairs under such demonstration projects in such fiscal year and the number of veterans to or for whom such reimbursements or payments were made; and

(3) the total amount of the expenditures by the Administrator of Veterans' Affairs for such reimbursements and payments under such demonstration projects in such fiscal year.

[From the Congressional Record, Vol. 131, No. 55, pp. S5289-S5290--Senate, May 2, 1985]

S. 1052. A bill to amend title 38, United States Code, to require the Administrator of Veterans' Affairs to carry out demonstration projects to furnish chiropractic services to certain veterans and to evaluate the cost effectiveness of furnishing such services to such veterans; to the Committee on Veterans' Affairs.

VETERANS' CHIROPRACTIC SERVICES DEMONSTRATION PROJECTS ACT

Mr. THURMOND. Mr. President, today I am introducing legislation to authorize the Veterans Administration to conduct demonstration projects for the purposes of providing chiropractic services to eligible veterans and evaluating the therapeutic benefits and cost-effectiveness of such services. I am pleased that Senator DECONCINI has joined as an original cosponsor of this measure.

Current law authorizes the Veterans Administration to provide chiropractic services to veterans, and Veterans Administration physicians may, on a case-by-case basis and at the expense of the VA, refer an eligible veteran to a private chiropractor for treatment. However, despite this authority, few veterans have actually been referred to private chiropractors by VA physicians.

Mr. President, chiropractic treatment has become a recognized and effective means of treating certain physical impairments and disorders. In virtually all other areas of the Federal health care delivery system, Congress has recognized the important role of chiropractic care. Moreover, a number of States also include chiropractic services under their medical assistance programs. It is my strong belief that our Nation's veterans deserve the same access to medical treatment, including chiropractic treatment, as that available to recipients of other Federal and State health care programs.

At this point, it is appropriate to list some of the programs on the Federal level which authorize chiropractic services. The provision of chiropractic services is authorized for eligible persons under the Medicare and Medicaid Programs. Chiropractic services are provided to Federal employees under several health plans offered through the Federal Employee Health Benefit Program. Federal employees have chiropractic coverage under the Federal Employee Workers' Compensation Program. Chiropractic health services are included in the Railroad Retirement Act. Last year, with passage of the Department of Defense Authorization Act of 1985, Public Law 98-525, Congress authorised the Secretary of Defense to conduct demonstration projects for the purpose of evaluating the cost-effectiveness of chiropractic services under the CHAMPUS Program.

Mr. President, it is time that the policy and practice of the Veterans' Administration be brought in conformity with these programs. The chiropractic patient population today in the United States is estimated to be between 10 and 20 million. Our Nation has some 28 million veterans, and there is no doubt that a substantial number of our veterans who receive medical care at Veterans' Administration facilities are either actual or potential chiropractic patients.

Mr. President, the legislation which I propose today would authorize the Veterans' Administration to conduct no less than five demonstration projects in five different geographical regions of the country to provide chiropractic services to eligible veterans. In the conduct of these demonstration projects, the VA would enter into cooperative agreements with no less than five chiropractic colleges to coordinate the provision of chiropractic services to veterans and perform clinical research and data collection regarding the therapeutic benefits and cost-effectiveness of such services.

Under the provisions of my bill, an eligible veteran may receive no more than $600 in chiropractic services in any 12-month period, and the Administrator would be authorized to prescribe a limit on the amount payable to any chiropractic college in any fiscal year under a cooperative agreement. In addition, total expenditures for chiropractic services under the demonstration projects would be limited to $2,000,000 in any fiscal year. It is intended that the demonstration projects be funded from appropriations for medical and prosthetic research and development.

Mr. President, although the House of Representatives has failed on three previous occasions to accept Senate-passed legislation authorizing the establishment of a pilot program of chiropractic services for veterans--legislation which I introduced—it has joined the Senate in strongly urging the Veterans' Administration to reevaluate its position and use existing authority to provide chiropractic services in appropriate cases as part of the medical care afforded to veterans. This message has been virtually ignored by the Veterans' Administration. I, therefore, urge Congress to send a stronger message to the Veterans' Administration on this matter by favorably considering this legislation.

[27]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 7 1985

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 1052, 99th Congress, a bill entitled the "Veterans' Chiropractic Services Demonstration Projects Act of 1985." Based on professional, programmatic, and budgetary concerns, we oppose enactment of this bill.

This bill would require VA to conduct five "demonstration" projects over a three-year period to evaluate the therapeutic benefits and cost-effectiveness of furnishing chiropractic services to veterans. It would direct that, in developing the projects, VA enter into cooperative agreements with chiropractic colleges to perform jointly clinical research on the question of benefits and cost-effectiveness, and to undertake jointly certain unspecified "coordination" of chiropractic services to eligible veterans. S. 1052 also describes a class of veterans eligible to be reimbursed for chiropractic services under the demonstration projects.

Furthermore, the bill directs VA to provide reimbursement in accordance with a schedule of charges established by the Administrator in consultation with other Federal agencies and public and nonprofit organizations that reimburse for chiropractic services. The proposed VA schedule of reasonable charges is to be "consistent" with the reasonable charges allowed under the Medicare program, but reimbursements to individual veterans could not exceed $600 per year. The overall appropriation authorized by this bill for chiropractic services (but not for other elements of this bill such as required research) is $2 million per fiscal year. Unless later extended, no reimbursement under the bill's demonstration projects could be made after September 30, 1987.

The concept of conducting a demonstration project, as proposed in S. 1052, is premised on the notion that one would intend to establish a permanent program based on the "success" of the demonstration. We strongly recommend against establishing such a program. We believe that it is important to note that a requirement that VA provide or reimburse for chiropractic services would represent a fundamental change in the function, focus, and orientation, and potentially in the structure, of the VA health care system. This bill is presumably based on the premise that the VA presently lacks the ability to provide a full range of quality care and services to eligible veterans. We reject that premise.

The VA is required by law to provide a complete hospital and medical service for the care of veterans and to employ the services of licensed physicians who hold a degree of doctor of medicine or osteopathy from a college or university approved by the Administrator. The therapeutic capabilities of the existing VA medical staffs and consultants are comprehensive and flexible, and fully meet the needs of all veteran patients. We strongly believe that disorders of the musculoskeletal system are skillfully and appropriately treated in the VA by physicians, medical and surgical subspecialists, and specialized support personnel. Therefore, because of the strengths and capabilities of the VA health care system to provide this treatment, we frankly do not see a role for chiropractic in that system.

Unlike Medicare and other systems, VA's health care system is primarily a provider of care, not a passive reimbursement mechanism, and Congress has clearly delineated and limited the circumstances under which fee-basis or contract care may be authorized. Other than in certain emergencies, the law does not permit VA to reimburse for fee care at all unless VA physicians have determined in advance that care is needed and have authorized it. This bill, on the other hand, does not provide a satisfactory mechanism to assure that there is a need for such services.

Moreover, while it is not our intention to rekindle debate over the scientific or therapeutic validity of chiropractic care, our efforts to study the available literature have revealed little evidence that chiropractic schools or the chiropractic industry at large has conducted significant scientific research regarding the efficacy of chiropractic. We question then why VA should be asked to undertake an effort, as proposed in this bill.

Enactment of S. 1052 would require expenditures far in excess of the $2 million limit on direct payments for chiropractic services. Meeting the bill's requirement that VA participate in clinical research and data collection to evaluate the therapeutic benefits and cost effectiveness of providing chiropractic services to veterans is likely to cost at least $7 million. We would envision the need to design a study that would compare chiropractic with other forms of therapy. From a purely scientific point of view, this would be a very complex undertaking. Establishing the health problems to be studied and recruiting sufficient numbers of patients to obtain statistically significant data would both prove very difficult. Equally troublesome would be establishing the effectiveness of treatments. For example, there are simply very few objective measures for determining improvement of low back pain, one of the most common musculoskeletal problems.

We wish to emphasize that VA does not wish to limit the freedom of choice for a veteran as a health-care consumer. Veterans, of course, have freedom of choice in their selection of health care providers and modes of care. We also know that many eligible veterans, for a variety of reasons, do not routinely obtain their care from VA. Some may seek care from sources outside the medical profession. However, we do oppose any attempt to redesign inadvertently the VA health care system in an effort to increase further a veteran's choices for health care, such as for chiropractic services in the veteran's community at VA expense.

Finally, it must be noted that VA has the challenge of meeting its existing mission in the face of fiscal constraints. Accordingly, we would hope to avoid the imposition of new requirements, such as provided for in this bill, that would oblige VA to divert scarce resources. For these reasons, we strongly oppose this legislation.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez / Deputy Administrator, for
HARRY N. WALTERS
Administrator

BEST COPY AVAILABLE

Senator CRANSTON. We will now proceed with the witnesses, Dr. John Gronvall, Deputy Chief Medical Director, accompanied by Dr. D. Earl Brown, Jr., Associate Deputy Chief Medical Director, and Mr. Audley Hendricks, assistant general counsel, and Dr. John Mather, Assistant Chief Medical Director for Geriatrics and Extended Care, Department of Medicine and Surgery, Veterans' Administration, Washington, DC.

Welcome.

TESTIMONY OF DR. JOHN A. GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR, ACCOMPANIED BY DR. D. EARL BROWN, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; AND A. AUDLEY HENDRICKS, ASSISTANT GENERAL COUNSEL, VETERANS' ADMINISTRATION, WASHINGTON, DC

Dr. GRONVALL. Thank you very much, Mr. Chairman.

It is a pleasure for us to have the chance to be here today to express our views on the various pieces of legislation pending before the committee.

We have submitted a very long and detailed commentary on each of these bills, and I would ask that that be made a part of the record of the hearing.

Senator CRANSTON. Without objection, it will be made a part of the record.

Dr. GRONVALL. Thank you.

Because our opening statement, the formal opening statement, is so long, I will not really attempt to summarize all of the parts of it, but rather, in the interest of time, in just a few minutes, to pick out what we think are some of the most important provisions before the committee today and make comments only on them.

Our formal statement I should note deals with all of the legislation pending, with the exception of the bill S. 1007, the bill introduced by Senators Denton and Boschwitz regarding alternative means of acquiring facilities.

We have not completed our analysis of that bill, and as soon as we have completed it we will provide a full commentary and report for the record.

Let me, then, turn to the matters that we do comment on—take first the bill S. 875. This is the bill that would establish a 3-year pilot program to convert 10 of our existing Vet Centers to Vietnam Veteran Resource Centers.

We believe that there are many appealing concepts embodied in this proposal, but it is our judgment that there is no need for new legislation in this area, and therefore, we do not favor the adoption of this legislation.

Our detailed statement lays out the programmatic and administrative reasons why we believe this bill might, in fact, have a negative impact on our programs for Vietnam veterans.

Turning, then, to the bill S. 876, our statement, again, presents a detailed analysis of each of the provisions. We are unable to support many of the proposals as drafted, but we do believe that the bill addresses a number of important issues aimed at keeping patients in noninstitutional settings. And we certainly support that goal. Even though we do not support the specific provisions as drafted, we would like to work with the committee staff to perfect the ideas and the concepts embodied in the bill into legislation that we believe would be more constructive and that we could support.

Let me turn, then, to a section in S. 876 and also section 7 of your bill, Senator Cranston, regarding provisions dealing with quality assurance.

This is an area in which we do want to make strong comments, and we have come to the conclusion, after analyzing both of these bills, that we do not believe there is need for new legislation in this area.

It's our judgment—and we believe that is supported by evidence—that the care available within the VA is, in fact, second to none and that the VA system at the present time is subject to a more intensive and extensive level of review than is the case in any comparable private sector set of health facilities.

Dr. John Ditzler, the newly appointed Chief Medical Director, from the outset has put quality of care and quality assurance measures at the very top of his agenda of importance. He has realigned our departmental activities in reviewing quality assurance, has established a Quality Assurance Office reporting directly to him as Chief Medical Director, and has just recently designated Dr. Frank Conrad to be Director of that office.

We are also currently in the process of implementing a medical-district-based peer review system as an element of our quality assurance program, and we believe that this will make a considerable improvement in our quality assurance activities.

Further, we believe that the proposal for the use of morbidity and mortality data, as described in the bills, might, in fact, be detrimental to the quality assurance system. And we believe that such data are best used directly by health professionals who are involved in peer review, rather than making an indiscriminate public release of such data, which we think may lead to damaging public confidence rather than improving public understanding of quality assurance.

Let me make brief comments on Senate bill 6, introduced by Senator Cranston. There are numerous proposals in that bill covered in our formal statement. We favor the extension of the Vietnam era for veterans' benefits. We favor extension of our contract authority for rehabilitation for drug and alcohol disabilities. And we favor Amendment No. 22.

Other provisions of S. 6 we do not favor for the reasons given in our full statement.

The final comment I would make relates to our understanding that the committee is considering a bill, S. 1052, that would establish five demonstration projects regarding chiropractic care, to evaluate the therapeutic benefits and cost-effectiveness of furnishing chiropractic services to veterans.

We strongly recommend against the adoption of this program. We believe that it would represent a fundamental change in the VA health-care system, which we believe would be negative and would not build on the strengths of our system.

It's not our intent here today to rekindle the entire scientific debate on chiropractic, but we do not believe it is appropriate for the VA to be charged to undertake the research necessary, at a cost of several million dollars, to investigate the question of the benefits of chiropractic.

Mr. Chairman, that concludes my opening summary of our longer formal statement. I and my colleagues and other members of the VA staff who are here would be pleased to respond to questions.

Chairman MURKOWSKI [presiding]. Thank you very much, Dr. Gronvall. I appreciate your testimony.

[The prepared statement of Dr. John A. Gronvall, Deputy Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, follows:]

PREPARED STATEMENT OF DR. JOHN A. GRONVALL, DEPUTY CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee:

We are pleased to be here this morning to offer our views on legislation pending before the Committee.

Mr. Chairman, we will begin by commenting on the provisions of two VA health care bills you introduced, S. 875 and S. 876. We will then address the various provisions of S. 6, introduced by the Ranking Minority Member of the Committee, Mr. Cranston. Finally, we will comment on the provisions of Mr. Thurmond's bill pertaining to chiropractic services.

S. 875--VIETNAM VETERANS' RESOURCE CENTERS PILOT PROGRAM

S. 875 would establish a three-year pilot program to convert the mission of ten of the VA's readjustment counseling centers (Vet Centers) into facilities tasked to provide on site a variety of services to Vietnam-era veterans who are eligible for readjustment counseling. The centers, which would be known as Vietnam Veterans' Resource Centers, would continue to provide eligible veterans with readjustment counseling and related mental health services, and would additionally provide drug and alcohol abuse treatment and rehabilitation; employment counseling, training, placement services, and veterans benefits outreach services. The bill provides that veterans eligible to receive services at the new centers would be limited to those now eligible for readjustment counseling services.

Administration of the pilot program in the ten new resource centers would be under the Deputy Administrator of Veterans Affairs. The "Team Leader" in each of the Vet Centers designated to become resource centers would become the Resource Center Director. The staff of each resource center would also include other persons now working in the Vet Center, personnel experienced in career development and vocational rehabilitation and counseling, one or more Veterans Benefit Counselors; and personnel experienced in drug or alcohol abuse treatment, counseling and rehabilitation. The bill would also authorize the Secretary of Labor to assign disabled veterans outreach program specialists to the centers.

The concept of converting some Vet Centers into expanded one-stop service centers has a certain appeal. Nevertheless, we see serious problems in both the concept as well as the specific provisions of the bill. Foremost among our concerns is that the proposal would move the Vet Centers in the direction of a self contained system autonomous from the larger VA system. We believe the readjustment counseling program has greatly improved, in part through VA having achieved greater integration and coordination between that program and the overall VA system. We believe that the direction we have taken with that program offers the greatest capacity to assist veterans.

In contrast, the approach proposed by S. 875 would be very costly to establish, manage, and evaluate. We do not believe that the experience we might gain from operating such a pilot program would outweigh the costs, particularly in light of other demands on these resources. Finally, we believe that Vet Centers are already successfully carrying out many of the functions which this bill would mandate and we see little reason to conduct an experiment of this magnitude.

It is important to understand that many Vet Centers now provide a combination of services to the veteran associated with readjustment counseling. In that connection, we note that 120 Vet Centers now have a Department of Labor employee working at the Vet Center on a regular basis for a set number of hours per week performing employment counseling. In addition, a number of Vet Centers have an employee from the Department of Veterans Benefits working regularly to provide benefits counseling. In a few instances, substance abuse counseling is provided if the Vet Center counselor on staff has the necessary qualifications to provide such counseling. We strongly believe that local program managers should be left with the discretion to provide the services they deem necessary in the most effective and efficient manner possible. It may be more difficult and more costly to provide services outside the medical center or regional office setting, and we do not believe broad based service delivery by Vet Centers should be mandated. One major reason for the success of the Vet Centers over the past five years has been the sharp focus of their mission. We believe that the pilot program would tend to diffuse that mission and thus not take account of an important lesson that has been learned.

Finally, separate and apart from the merits of the pilot program, we are uneasy with the organizational scheme under which such a program would be administered.

Mr. Chairman, I will now turn my attention to S. 876, a bill containing five major provisions.

ALTERNATIVE TO NURSING HOME CARE-PILOT PROGRAM

Section 2 of S. 876 would require VA to conduct a three-year pilot program in five geographic areas to furnish eligible veterans with medical, rehabilitation, and social services which would obviate the need for nursing home care. The program would commence on January 1, 1986. The bill contemplates that VA would provide these services by contract with public and private providers where available, or if that were not feasible, the VA could directly provide health related and supportive services. Veterans eligible to receive services would be those who would otherwise be receiving care in community nursing homes and who, as a result, would be able to reside at home. The measure calls for VA, in administering the program, to give priority to veterans over 65 years of age and those who are catastrophically disabled. Under the proposal, the cost of carrying out this pilot program in any fiscal year could not exceed 60 percent of the cost that the VA would have incurred if we had instead furnished community nursing home care to the participating veterans.

Congress provided, in 38 U.S.C. § 4101, that "[the] primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service." That mandate has generally been viewed as contemplating that VA will provide veterans with all needed medical services, either in VA operated facilities or, where necessary, in facilities for which the VA contracts. This mandate clearly excludes the provision of nonmedical social or supportive services which this proposal contemplates. Providing such VA assistance as homemaker or chore services, as proposed, would in part duplicate the assistance for which the basic aid and attendance allowances are currently paid to many veterans under 38 U.S.C. § 314(r)(1). Basic aid and attendance allowances are paid to eligible veterans so they may obtain nonprofessional help to meet such basic needs as feeding, washing and dressing themselves. Moreover, in many communities these services are already available to those who would otherwise need nursing home care. Provision of these services by the VA directly or under contract as contemplated by the law would duplicate these services.

Nevertheless, VA favors the basic concept of developing alternatives to institutional care. For example, we have submitted draft legislation to Congress which would authorize VA to conduct a three-year pilot test of "respite care." Under this proposal, VA would be authorized to furnish care at a limited number of facilities to chronically ill veterans who have the highest claim to VA care--service-connected disabled veterans--who have been receiving hospital based home care. The purpose of this proposal is to give brief, planned periods of respite to members of the veteran's household who would otherwise be rendering care in the home. This pilot program would provide a basis for our evaluating the efficacy of the "respite care" concept in avoiding or delaying the need for prolonged institutionalization and its potential for cost avoidance. The respite care pilot program would only require use of existing VA funds and would be targeted at the service-disabled veteran. Under our proposal, respite care would be furnished in existing operating beds with placements based on local needs assessments and resource availability.

We, of course, have several other programs, such as the adult day health care program and the hospital based home care program, which have long been recognized as providing important alternatives to institutional care. The VA also has broad authority already to conduct an evaluation of its noninstitutional treatment programs. Accordingly, we see no need for this provision and view the provision as unduly prescriptive in directing the scope and operation of the pilot program. In many respects, the requirements of section 2 are so specific that they would deprive VA of the latitude needed to derive real benefit from any such pilot program.

More importantly, we do not favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources. However, we estimate the cost of this pilot program would be substantial.

TREATMENT AND REHABILITATION FOR ALCOHOL OR DRUG DEPENDENCE DISABILITIES

Section 3 of S. 876 would extend without limitation the VA's authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. The existing authority for VA to operate this program expires on September 30, 1985. We strongly support extension of VA's authority to operate this program, but we do not at this time support making the authority permanent. We recommend that the program be extended for three years and we have submitted legislation to extend the authority through Fiscal Year 1988.

Since April 1980, the VA has operated a program authorized by Public Law 96-22 under which certain veterans suffering from alcohol and drug dependence have been provided treatment and rehabilitation in community contract facilities such as halfway houses. In authorizing its establishment, Congress called for VA to plan and operate a pilot program so as to demonstrate both the medical advantages and cost effectiveness of this care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program. The required study indicated that those patients who were placed under this program were, on the whole, least able to cope in society.

VA prides itself on the quality of our substance abuse programs. Nevertheless, our study tends to show that, for approximately six to eight percent of VA patients admitted for substance dependence or abuse disabilities who are essentially alienated from society, many without family support and with no job in the community, contract halfway house care with its peer setting can greatly help reentry into the community and acquisition of self-help and job skills. This six to eight percent minority tends to successfully reenter the job market and place in the community better from halfway house care than from VA hospitals. We have found that the halfway house provides more definitive rehabilitation of recovery resistant cases requiring continued residential support and extensive work on self-help skills. It also offers economic advantages of shortening the total VA hospital-bed days by providing treatment and rehabilitation in a lower cost residential environment.

As of the end of FY 1984, 83 VA medical centers had contracts with 297 non-VA community based programs, and 16,685 veterans had been outplaced for treatment in these contracted facilities. The program evaluation study revealed strongly encouraging followup measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse prone veterans to warrant continued authorization for this program.

Section 3, however, would also require that the Administrator very closely monitor the operation of the program, collect an inordinate amount of statistical data for each and every contract facility, and annually report this data to the Congress. Specifically, VA would be required to collect data for each contract facility (there are 309 presently) on the level of success, rate of successful rehabilitation, the rate of readmission, the ability of the program to aid veterans in transition back to the community, the average cost per veteran, and the appropriateness of such cost when contrasted with costs in other community based programs.

We have no objection to providing Congress a report in light of the further experience we gain with the drug and alcohol halfway house treatment program aimed at assessing the continued usefulness of the program and determining if permanent extension of the program would be warranted. We object, however, to the requirement of the bill that we collect very specific and detailed data for each contract facility, aggregate it in Central Office, and report it all to the Congress. First, such data can be very misleading and not very useful since the number of veterans being treated in any given facility is generally not large enough to make a statistically significant assessment of the program. For example, if only two veterans are being treated in a given facility, and only one is successfully rehabilitated, those data suggest a 50% failure rate. In fact, the facility may have a better success rate when all patients are considered, both veterans and nonveterans. Moreover, we must object in general to the imposition of voluminous data collection and reporting requirements. Thus, we object to the provisions mandating that we collect, aggregate, and report statistics which may be of questionable validity.

COMMUNITY RESIDENTIAL CARE FOR CHRONICALLY MENTALLY ILL PATIENTS

Section 4 of S. 876 would amend section 630 of title 38, United States Code, to mandate the establishment of a three-year community residential care pilot program for chronically mentally ill veterans. The bill would require the establishment of a program, conducted in five geographic areas, under which VA would contract for "care" to be furnished in community residential facilities. The measure would limit VA placements into such program to chronically mentally ill veterans who, but for receiving care in a community residential facility, would otherwise receive VA inpatient care and by virtue of participation in the program eventually would be able to reside at home. The bill would mandate that the program involve the use of VA psychiatric day treatment and hospital based home care programs and that administering facilities employ "unified case management services."

Section 4 of the bill appears to simply expand the VA's existing Community Residential Care Program (CRC), by allowing VA, on a pilot program basis, to pay for the cost of residential care for one group of veteran patients, the chronically mentally ill patients. Enacting such a measure would seriously damage the Community Residential Care Program, and, accordingly, we cannot support the proposal.

Under the existing Community Residential Care Program autnorized by 38 U.S.C. § 630, VA, in essence, inspects and accredits residential care facilities, and refers patients to those facilities. VA does not, however, pay for this nonmedical residential "care". The fact that the veteran rather than the VA, pays those costs is in keeping with the general statutory mandate that the Department of Medicine and

Surgery provide veterans with all necessary hospital and medical services, but not with nonmedical social or supportive services, as discussed in our comments on section 2 of this bill. That section would establish a pilot program to be an alternative to nursing home care and it would also involve provision of supportive services. We reiterate our earlier comments that other veterans' benefit programs, and other programs in the community, should be the principle mechanisms by which nonmedical support services are provided to veterans.

QUALITY ASSURANCE

Section 5 of S. 876 would mandate that the Administrator establish and conduct a comprehensive medical quality assurance program to monitor the quality of health care furnished by the VA. Under the proposal, the Department of Medicine and Surgery would conduct the quality assurance program and the Office of the Inspector General would be charged with monitoring the overall operation of the program. Given the VA's record of performance in this area, we see no need for legislation such as section 5.

We in the VA attach great importance to the quality of care provided to our veteran patients. It is our belief that any objective evaluation of the quality of care available in the VA system would lead one to conclude that eligible veterans can avail themselves of service in the VA confident that such service is safe, effective, and professionally competent. To assure that fact, we are committed to the maintenance and continued improvement of an effective medical quality assurance program, and require that a comprehensive peer review based program exist in every VA medical facility. VA's program is mandated by, and governed by regulations which are formally published at 38 C.F.R. §§ 17.500-17.540. The primary elements of the VA quality assurance program, known as the Health Services Review Organization (HSRO), generally encompass the measures which the Joint Commission on the Accreditation of Hospitals (JCAH) requires for a facility to be accredited. As you know, it is the policy of the VA that all medical facilities in our system comply with the accreditation requirements of the JCAH. Additionally, VA facilities are monitored by, and often accredited by numerous other federal regulatory agencies, professional associations, and accrediting bodies including the Nuclear Regulatory Commission, the American Association of Blood Banks, and the College of American Pathologists, to name but a few.

There are numerous other mechanisms to assure that quality care is provided in VA health care facilities. Many of our medical centers are affiliated with medical schools, giving patients the benefit of that added resource. Many advisory boards and committees monitor various aspects of VA health care. Additionally, the Congress, both directly and through the GAO, regularly audits and reviews clinical programs for effectiveness and efficiency. Finally, we are currently implementing a Medical District based peer review program which will add another dimension to the quality assurance system. Computer assisted analyses of medical records and other existing and planned data bases will enable groups of specially selected VA physicians in each Medical District to monitor clinical activities at each facility, making judgments of quality based on specially developed standards and criteria, forwarding essential feedback to colleagues who are determined to keep pace with constantly improving standards of care.

The proposal would require that the Administrator delineate the responsibilities of the Office of the Inspector General (IG) and the Department of Medicine and Surgery (DM&S) with respect to monitoring, evaluation, and conduct of the VA's quality assurance program. We believe those respective roles have been well established under the Administrator's existing authority to delineate those responsibilities. As stated above, existing regulations, which were established by the Administrator, now mandate that the conduct of a program to monitor and evaluate the quality of care is a function to be performed by health care professionals in DM&S. It is also clearly the function of the Inspector General's office, as part of the auditing function vested in that office by the Inspector General Act, to make certain that a quality assurance program exists, and that the required procedures in that program are being correctly followed.

The bill would also direct that the Administrator allocate to the Inspector General necessary resources and personnel with appropriate qualifications necessary to review quality assurance programs. Resources are, and should continue to be, allocated in the normal budgetary process. We do not believe there has been a problem with allocation of resources to the Inspector General. The Inspector General Act grants authority to the IG to appoint personnel, including those with special qualifications as deemed necessary. That function is now being carried out by the IG without problems, and we do not believe a provision directing the Administrator to allocate personnel to the IG is necessary or appropriate, particularly when it could be construed as redundant vis a vis the Inspector General Act.

We also oppose the provision of section 5 which would mandate that the Administrator allocate sufficient travel funds to to enable the Department of Medicine and Surgery to carry out its quality assurance function. Travel funds are, and should continue to be, allocated in the normal budgeting process. The effect of this provision would be, in essence to state in law that quality assurance activities have a greater need for travel dollars than all other DM&S activivities requiring travel, and that already scarce travel funds must be allocated to that program regardless of other needs. We submit that such a provision is potentially deleterious.

The bill would also require that DM&S establish mortality and morbidity rate norms for all surgical programs in the VA, and then collect data on actual mortality and morbidity rates to compare with the expected rates. Additionally, the bill would require that data be collected regarding factors which would affect such rates, including characteristics of the patient population, the level of risk involved in the procedure based upon patient age, the kind of illness involved, and the severity of the illness. Under the bill, the Chief Medical Director would be required to contrast mortality and morbidity rates for "each surgery program" with the norms, and determine if deficiencies in the quality of care exist. The Inspector General would be required to review and report to the Congress on the comparison between actual rates and the mortality and morbidity norms.

The language of this provision, and accordingly the task imposed on VA, is unclear. The bill would have VA focus a major part of its quality assurance program on mortality and morbidity for each surgery program including, but not limited to, each cardiac surgery program. The term "surgery program" does not have widespread use in the VA. We do have designated "surgery programs" in three areas, cardiac surgery, renal transplant surgery, and heart transplant surgery. All other surgical procedures are carried out by specialty, e.g. thoracic surgery or urological surgery. If the bill is intended to impose the requirements pertaining to mortality and morbidity only on the three designated programs, the task could perhaps be technically accomplished without undue difficulty. On the other hand, if the intent of the bill is that mortality and morbidity rate norms be established for every surgical procedure, and data be collected on every procedure performed in every VA facility, the task would be monumental.

If we assume the bill requires establishment of norms, and collection of mortality and morbidity rates for all surgical procedures, we must be prepared to undertake an extremely costly and time consuming effort which would produce results which would be of very questionable value.

Contrasting mortality and morbidity rates with rate norms is not a definitive method for determining quality of care. Many factors affect mortality and morbidity statistics such as age, economic status, health status, and patient referral patterns. Only qualified professionals have the training to evaluate those factors. Weighing the uncertain benefits of this proposal against the extraordinary costs it would impose, we urge the Committee to reject it. We believe other more conventional quality assurance mechanisms now in existence can make better use of surgical mortality and morbidity data. For example, physicians in VA hospitals, as part of the existing quality assurance program, conduct mortality/morbidity conferences. Such conferences are but one mechanism in the overall VA quality assurance program. The physicians meet, on a periodic basis, to review mortality and morbidity for surgical procedures. Typically, the conference might review a sampling of the records of all patients who underwent a specific surgical procedure during a specific time period. Such reviews, conducted by physicians who understand the meaning of mortality and morbidity data, and who are best able to assess that data, are a far more cost-effective and useful method for reviewing mortality and morbidity than the method proposed in this bill.

Finally, the bill would require that annually, the Inspector General's office should review the actual mortality and morbidity rates, contrast those rates with the established norms, and report the results of the review to the Congress. The Inspector General's office now performs cyclical audits of all VA medical centers at least once every three years. As part of such audits, that office would, if this bill were enacted, review mortality and morbidity statistics and contrast them with the established norms. Generally, this would be done as a sampling to make certain that the quality assurance mechanism is being conducted. However, we strongly oppose this provision if it is intended that the Inspector General annually review all morbidity and mortality rates for all procedures in all VA facilities, and then report the results to the Congress. Such a task would be an extraordinary effort in terms of cost and time, especially since the utility of the effort would be so questionable. We again reiterate that quality assurance should be a normal function of the medical staff, as it now is in the VA. It should not be converted into a mechanism used mechanically to attempt a centralized oversight function.

ADVISORY COMMITTEE ON VETERANS' ADMINISTRATION FACILITY PLANNING

Section 6 of S. 876 would require the Administrator to establish an Advisory Committee on Veterans' Administration Facility Planning, consisting of members of the public including individuals with expertise in pertinent health care policy and planning, clinical practice, and medical facility construction and veterans' representatives. The Secretaries of Defense and Health and Human Services and the VA's Chief Medical Director would be ex officio members of the Advisory Committee. The committee would be charged with reviewing and evaluating the VA's criteria for sizing VA medical facilities including methods for determining such criteria. In that connection, the committee would be required to evaluate access by veterans to the VA health care system, and they would develop recommendations for modification of sizing criteria. Annually, the committee would report to the Administrator who would in turn transmit the report with comments and recommendations to the Committees on Veterans' Affairs.

We oppose this provision. The establishment of an advisory committee is but one of several possible vehicles for an agency to obtain advice or expertise from outside the Government. We see no justification or need at this time for reliance on this particular advisory vehicle. Its work would be duplicative of major efforts taken by the Agency, and its establishment is unnecessary. We presently use a bed-sizing model developed jointly by VA and GAO under a congressional mandate, to "size" VA-planned medical facilities. The model is considered a state-of-the-art methodology and is constantly being evaluated and refined as appropriate. VA staff are assigned to VAMC Gainesville to work in conjunction with the University of Florida to improve the model and to make adjustments to the model to incorporate new policy developments such as the VA resource allocation methodology. There is a standing advisory group of experts on operations research, modeling and health care from other federal agencies and from the academic community who provide consultation to the project staff.

Thus the purpose this provision is intended to accomplish is already being met.

Mr. Chairman, I would now like to turn to the provisions of S. 6, introduced by Mr. Cranston.

VIETNAM ERA

Section 2 of S. 6, would expand the legal definition of the term "Vietnam era" to include the period from February 21, 1961 through August 4, 1964, if the veteran served in Vietnam during that time. VA supports this change in the law. We estimate that approximately 48,000 veterans served in Vietnam between February 21, 1961, the date established in Public Law 89-257 for acceptance of awards from foreign governments for service in Vietnam, and August 5, 1964, the date of the Gulf of Tonkin Resolution. Those veterans served under adverse conditions which can be considered akin to wartime conditions. It is reasonable that they be eligible to receive benefits for which wartime service in general, and Vietnam-era service in particular, is a requirement.

Veterans covered by this provision would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they also meet disability, income, and net worth requirements. Other benefits they might receive include certain burial benefits, readjustment counseling services, medical benefits under Public Law 97-72, and loan guaranty benefits in certain cases. The number of veterans who would be affected and who are not otherwise eligible for these benefits is not large. The estimated cost for these additional benefits is approximately $1.3 million for each of the next five fiscal years.

VA GRADE REDUCTION

Section 3 of S. 6 would prohibit the Administrator from implementing any systematic reduction of VA employees in any pay grade unless the Administrator first submits to both Committees on Veterans' Affairs, at least ninety days before implementing a reduction, a report containing a detailed plan and justification for the reduction demonstrating that VA has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to equivalent employees in other Federal agencies and non-Federal entities. Furthermore, this section directs the Comptroller General to submit to the Committees, within 45 days after the submission of this report, a report on VA's compliance with this provision and an opinion on the accuracy of the Administrator's determination.

Section 3 would inject the Congress into a management function, and VA opposes it. Obviously, any steps to control grade levels must be the object of careful study, but the analysis properly can and should be accomplished within an executive agency and not be conditioned upon any report to the committees of the Congress. We consider the definition of a grade reduction in section 3 of the bill to be overbroad. Arguably, this definition could be interpreted to require an advance report and determination as to virtually any systematic action which would result in grade reductions. Specifically, it could prevent us from reorganizing work, implementing new classification standards, complying with classification consistency review requirements directed by Office of Personnel Management, or generally reclassifying positions properly if any of the actions would result in a lower grade structure for any group of employees.

EXTENSION OF HEALTH CARE ELIGIBILITY FOR VETERANS EXPOSED TO TOXIC SUBSTANCES OR NUCLEAR RADIATION.

Section 4 would extend for almost three years the eligibility period for certain veterans who were exposed either to dioxin or other toxic substances while serving in Vietnam during the Vietnam era, or to ionizing radiation from nuclear detonation, to receive priority VA health-care services for disabilities not determined to be unrelated to that exposure. Currently, this eligibility period expires one year after the submission of a Congressionally mandated report on the epidemiological study being conducted by the Center for Disease Control (CDC) of the effects of exposure to dioxin on Vietnam veterans. The first report is due 24 months after the protocol for the study was approved, which was on February 24, 1984. Therefore, this health-care eligibility is scheduled to expire on February 24, 1986.

We believe that the necessary information for this study will not be sufficiently advanced by 1986 to permit Congress and the Administration to make final decisions on care for these veterans. The expiration date recommended by this provision--September 30, 1989--is based on the premise that, if, as planned, the CDC reports on the epidemiological study by September 1988, then Congress would have sufficient time to evaluate the results of that study and other relevant information and decide if further action may be needed. This proposed extension would permit Congress and the Administration to have sufficient time to analyze the results of the study and make a decision regarding health care for these veterans prior to the expiration of their eligibility.

TREATMENT AND REHABILITATION FOR DRUG AND ALCOHOL DEPENDENCE DISABILITIES.

Section 5 of the bill would extend for three years, until the end of Fiscal Year 1988, VA's current authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This provision is very similar to section 3 of S. 876, discussed earlier in this testimony. The principle difference between the two provisions is that section 5 of S. 6 would extend the program for three years which we favor while section 3 of S. 876 would extend the program indefinitely, which we oppose. S. 6 also differs from S. 876 with respect to reporting requirements.

MEDICAL QUALITY ASSURANCE RECORDS

Section 7 would amend section 3305 of title 38, which generally prohibits disclosure of medical quality-assurance records, to the extent that they are designated confidential by VA regulations. Implementing regulations provide for the release of aggregations of statistical data from quality-assurance studies and reviews except where those statistics would, by implication, reflect on the care and treatment being provided by a particular practitioner. Section 7 of the bill would overrule this regulation by requiring that all quality-assurance mortality and morbidity statistics for specific activities at individual VA hospitals be made public. No exception is provided. If this provision is enacted, the mortality and morbidity statistics (that is, the incidence by percentage of death or disease in a program) in a relatively small, single-provider program, such as cardiac surgery, would be publicly available and would reflect directly on the provider in that program. Particularly in major surgeries, such as cardiac surgery, we believe that an individual patient should be apprised of these statistics as they relate to his or her care. We believe further, however, that the VA quality-assurance review of the small, single-provider program will be seriously and detrimentally affected if such statistics must be made public. Accordingly, we strongly oppose enactment of this provision.

The compilation of mortality and morbidity statistical data reflects medical judgment. For example, when reporting mortality/morbidity statistics for a cardiac surgery program, a death, the underlying cause of which is cardiac surgery, but the immediate cause of which is pneumonia, could be reported as the result of pneumonia rather than complications resulting from the surgery. Such would reduce the cardiac surgery mortality rate. The public availability of this potentially critical data on individual providers will be a factor for consideration by other providers when they exercise their judgment on how to "count" their peer's patient mortality. We believe that this will, in fact, significantly influence the mortality and morbidity statistics reported in small, single-provider programs.

It should be pointed out that the Agency is currently developing an additional quality-assurance mechanism know as the Peer Review Organization (PRO). It is anticipated that this process will engender provider-specific statistics for all VA physicians. For the aforementioned reasons, we are concerned about the Agency's ability to garner accurate statistics in the PRO process if section 7 of S. 6 is adopted.

We believe that enactment of section 7 of this bill would also detrimentally affect other areas pertaining to patient care that are not related solely to the VA quality-assurance program.

These concerns include the fact that public availability of provider-specific data would have a chilling effect on the ability of the VA to retain physicians and other health care professionals. As you are aware, the performance of private practitioners in the community is not subject to public disclosure. Additionally, we believe that this statistical data could easily be misinterpreted by the veteran. As a consequence, such a veteran may well be dissuaded unnecessarily from seeking appropriate treatment. We are also concerned that surgical mortality rates may become a public indicia for assessing the care at a facility. Such a practice could discourage the use of surgery for high risk patients even though it is medically and ethically appropriate.

In considering the need for confidentiality for provider specific statistical data, it should be noted that at least one other Government agency faced concerns similar to VA's and has recently provided protection for such data.

The debate in the private sector has been ongoing for nearly ten years with respect to the release of statistical data collected first by PSROs and now PROs under the Medicare program. The Department of Health and Human Services (DHHS) recently published regulations (to be codified at 42 C.F.R. Part 476) which implement section 1160 of Title XVIII of the Social Security Act (Medicare). These regulations are nearly identical to VA's with respect to release of statistical data. DHHS rules provide that the PROs must disclose nonconfidential information to any person upon request, except aggregate statistical information that implicitly or explicitly identifies individual patients, practitioners, or reviewers.

Finally, we believe that the existing regulatory provision, i.e., 38 C.F.R. § 17.518((b), is adequate because it provides a reasonable balance between the public's need to hold the Agency accountable (e.g., through Congressional oversight) and the need of the Agency to protect the peer review process and the quality assurance program.

PROCEDURES FOR REDUCTION OR REVOCATION OF CLINICAL PRIVILEGES

Section 8 of the bill would provide that the procedures set forth in section 4110 of title 38, relating to disciplinary board proceedings involving VA physicians, dentists, nurses, and certain other VA health-care personnel employed under the title 38 personnel system for inaptitude, inefficiency, or misconduct, would also apply to cases involving proposed reductions or revocations in the clinical privileges of these personnel for the same charges. Under this provision, a disciplinary board could not impose a reduction or revocation of clinical privileges unless the person charged has been provided notice prior to the hearing and the reduction or revocation is on the basis of deficiency in clinical practice.

We believe that privileging is a clinical management function for quality patient care and for accreditation as required by the Joint Commission on the Accreditation of Hospitals (JCAH). Recognizing this, DM&S has appointed a Director for Quality Assurance who reports to the Chief Medical Director and whose office will work with VA medical centers to review the quality of their clinical privileging program.

We also believe that a disciplinary board proceeding is not the proper forum for the review of clinical privileges. In our view, the authority to decide on clinical privileges should remain with the facility's chief of staff, aided by local peer review through a professional standards board. Policies and procedures on approval and review of clinical privileges are included in each VA medical center's bylaws as required by the JCAH. JCAH requires that the bylaws include provisions for (1) a fair hearing, and (2) appellate review in the event of a recommendation adverse to the employee/ applicant. Typically, the VA facility implementation is a peer review process with a hearing and appeal available where there has been an adverse determination. The ACMD for QA will be issuing guidance emphasizing these process requirements. Generally, however, the review and delineation of clinical privileges is a joint cooperative process with the employee seeking approval of proposed privileges. It is designed to, and in the vast majority of cases operates to, protect against arbitrary withdrawal of privileges, without sacrificing the overriding priority, which is the well-being of VA patients.

This proposal would remove this decision-making authority from the local facility and vest it with the Chief Medical Director, with appeal to the Administrator. Not only would this change have substantial operational consequences with a substantial loss in flexibility;

but more significantly, it could result in a sacrifice of the confidentiality essential for effective quality assurance oversight. Discipline under section 4110 concerns a professional's employment status and is based on culpable inaptitude, inefficiency and/or misconduct. The privileging process concerns the capacity to treat patients and is based on an individual's clinical competence in a particular hospital activity as the result of his or her professional training and experience. These proposed new procedural requirements could delay the withdrawal of clinical privileges even if the health and safety of veteran patients were threatened. We believe these processes, the privileging on the one hand, and the disciplinary on the other, are properly separate and should remain separate. We strongly oppose this provision.

PILOT PROGRAM FOR NONINSTITUTIONAL CARE

Section 9 of this bill would require VA to conduct a 48-month pilot demonstration program in at least 5 geographic regions through which participating veterans would receive appropriate health and health-related services such as homemaker, personal care, and transportation services, from VA and appropriate public and private agencies. The express purpose of this program is to enable VA to evaluate the effectiveness, feasibility, and desirability of various actions that would provide veterans needed care in noninstitutional settings. VA would be required to report to Congress on the results of this program, with recommendations for appropriate administrative and/or legislative action, no later than 39 months following the commencement of the program. Section 9 calls for an authorization up to $10 million for this program for Fiscal Year 1987 and such sums as may be necessary for each of the subsequent four fiscal years.

As stated earlier in this testimony, VA favors the basic concept of developing alternatives to institutional care. In our comments on section 2 of S. 876, which would establish a pilot program to provide veterans with an alternative to nursing home care, we made reference to our own draft legislation to authorize conduct of a three year pilot test of respite care. We also indicated that we have several other programs, including adult day health care, and hospital based home care as alternatives to institutional care. Accordingly, we see no need for this provision.

Although section 9 would provide VA with the means to evaluate the benefits of providing new health-related services, the provision is unduly prescriptive in directing the scope and operation of the pilot program. We see no need for Congress to mandate minimum numbers of geographic areas or VA geriatric evaluation units to be included, for example. In many respects, the requirements of section 9 are so specific that they deprive VA of the latitude needed to derive real benefit from any such pilot program.

Finally, we cannot favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources. However, we estimate the cost of the program proposed under section 9 of the bill to be $4.3 million for Fiscal Year 1987 and $5.7 million for each of the next three fiscal years. We cannot justify the shifting of resources from our existing facilities and ongoing programs.

REPORT ON CERTAIN CIVILIANS WHO SERVED IN VIETNAM

Section 10 of S. 6 would direct VA and the Departments of Defense and Health and Human Services to submit a joint report to Congress on alternatives whereby the Government might provide services, such as health-care and monetary compensation for disabilities incurred, to Government employees and other civilians who served in Vietnam during the Vietnam era. We oppose this provision for several reasons. First, Title IV of Public Law 95-202 established a means for members of civilian support elements to apply to the Secretary of Defense for recognition of alternative service to establish veteran status. Second, we are unaware that civilians who served in organizations, like the Red Cross, are in such need of assistance for health insurance or other benefits, beyond what their own organization may provide, as to warrant Federal aid. We therefore do not believe it would be prudent to expend funds of the United States Government to conduct an extensive study on a potential problem where there appears to be little evidence that a real problem exists.

AMENDMENT TO S. 6--READJUSTMENT COUNSELING DELIMITING DATE

Mr. Chairman, I would like next to comment on the provisions of Amendment No. 22 to S. 6, introduced by Senator Cranston. This measure, characterized as a technical and conforming amendment, would amend section 612A(g) of title 38 to remove three words which appear to limit the provision of readjustment counseling services after September 30, 1988, to veterans who requested such services before that date. With the enactment of P.L. 98-160, Congress specifically deleted from section 612(a) of title 38, United States Code, language which had provided that to receive readjustment counseling services, an otherwise eligible veteran had to request those services within two years after the date of the veteran's discharge from active duty, or by September 30, 1984, whichever was later. However, subsection (g) of section 612A, which contained language listing such counseling to veterans who request it by September 30, 1988, was not amended. The amendment to section 612A in Public Law 98-160 does create some ambiguity as to whether Congress intended to retain a delimiting data for requesting counseling. The proposed amendment would clarify the matter and would be helpful. Accordingly, we favor the provision. We do not believe enactment of this provision will have a significant impact.

CHIROPRACTIC SERVICES

We understand tht the Committee is considering a draft bill which would require the VA to conduct five "demonstration" projects over a three-year period to evaluate the therapeutic benefits and cost effectiveness of furnishing chiropractic services to veterans. The bill would direct that in developing the projects VA enter into cooperative agreements with chiropractic colleges to perform jointly clinical research on the question of benefits and cost-effectiveness, and to undertake jointly certain unspecified "coordination" of chiropractic services to eligible veterans. The bill describes a class of veterans eligible to be reimbursed for chiropractic services under the demonstration projects. The bill directs the VA to provide reimbursement in accordance with a schedule of charges established by the Administrator in consultation with other Federal agencies and public and nonprofit organizations that reimburse for chiropractic services. The proposed VA schedule of reasonable charges is to be "consistent" with the reasonable charges allowed under the Medicare program. The reimbursements to individual veterans could not exceed $600 per year, and the overall appropriation authorized by this bill for chiropractic services (but not for other elements of this bill such as research) is $2 million per fiscal year. Unless later extended, no reimbursement under the bill's program could be made after September 30, 1987.

Surely the concept of conducting a demonstration project, as proposed in the draft bill, is premised on the notion that one would intend to establish a permanent program based on the "success" of the demonstration. We strongly recommend against establishing such a program. We believe that it is important in your consideration of this bill that you be aware that a requirement that the VA provide or reimburse for chiropractic services would represent a fundamental change in the function, focus, and orientation, and potentially in the structure, of the VA health care system. If this committee is to consider such legislation it would presumably be based on the premise that the VA presently lacks the ability to provide a full range of quality care and services to eligible veterans. We reject that premise.

The VA is required by law to provide a complete hospital and medical service for the care of veterans and to employ the services of licensed physicians who hold a degree of doctor of medicine or osteopathy from a college or university approved by the Administrator. The therapeutic capabilities of the existing VA medical staffs and consultants are comprehensive and flexible, and fully meet the needs of all veteran patients. We strongly believe that disorders of the musculoskeletal system are skillfully and appropriately treated in the VA by physicians, medical and surgical subspecialists, and specialized support personnel. We urge this committee to recognize the strengths and capabilities of the VA health care system. We view that system as relatively unique in itself and in the capabilities it offers veterans. Frankly, we do not see a role for chiropractic in that system.

Proponents of such legislation ask why the veteran should not be afforded freedom of choice, and be permitted to receive chiropractic services in his community at VA expense. Veterans, of course, have freedom of choice in their selection of health care providers and modes of care. We know that many eligible veterans, for a variety of reasons, do not routinely obtain their care from VA. Some may seek care from sources outside the medical profession. We do not ask you to attempt to regulate the freedom of choice veterans have as health care consumers. We do ask that you do not inadvertently redesign the VA health care system in an effort to increase further the choices available.

Unlike Medicare and other systems, VA's health care system is primarily a provider of care, not a passive reimbursement mechanism. Congress has clearly delineated the circumstances under which fee-basis or contract care may be authorized. Those circumstances are limited, as they should be. Other than in certain emergencies, the law does not permit VA to reimburse at all unless VA physicians have determined in advance that care is needed and have authorized it. This bill does not provide a satisfactory mechanism to assure that there is a need for such services.

It is not our intention to rekindle debate and attempt to persuade you at this time to reject the scientific or therapeutic validity of chiropractic. Our efforts to study the available literature, however, have revealed little evidence that chiropractic schools or the chiropractic industry at large has conducted significant scientific research regarding the efficacy of chiropractic. We question then why the VA should be asked to undertake such an effort, as proposed in this bill.

Enactment of this bill will require expenditures far in excess of the $2 million limit on direct payments for chiropractic services. Meeting the bill's requirement that VA participate in clinical research and data collection to evaluate the therapeutic benefits and cost effectiveness of providing chiropractic services to veterans is likely to cost at least $7 million. We would envision the need to design a study that would compare chiropractic with other forms of therapy. From a purely scientific point of view, this would be a very complex undertaking. Establishing the health problems to be studied and recruiting sufficient numbers of patients to obtain statistically significant data will both prove very difficult. Equally troublesome will be establishing the effectiveness of treatments. For example, there are simply very few objective measures for determining improvement of low back pain, one of the most common musculoskeletal problems.

Finally, Mr. Chairman, let me highlight the fact that VA has the challenge of meeting its existing mission in the face of fiscal constraints. Accordingly, we would hope to avoid the imposition of new requirements that would oblige VA to divert resources for such programs.

As we conclude our prepared testimony today, one final point might be appropriate to mention in the Committee's consideration of the bills we have discussed. We recognize the important role this Committee plays in the oversight of VA programs. It would appear, however, that if the bills we have discussed are favorably reported without amendment by this Committee, it would require VA over the next three fiscal years to provide or participate in providing Congress some 20 different reports. We do not believe this reporting burden is necessary.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you, or any other member of the committee may have.

Chairman Murkowski. I apologize for not being here earlier, but I have had an agonizing morning at the dentist.

So, I'm going to refrain from lamenting on my opening statement. I will enter it into the record as if read. And, if Mr. Principi wants to summarize it, that's fine.

Do you have any comments?

Mr. Principi. No, sir.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman Murkowski. Good morning and welcome to the Senate Veterans' Affairs Committee hearing on legislation related to veterans' health-care programs. We look forward to receiving testimony from a most distinguished list of witnesses. I would like to take this opportunity to welcome them to this morning's hearing.

We will receive testimony on the bills which I have introduced, S. 875, the proposed "Vietnam Veterans' Resource Center Act of 1985," and S. 876, the proposed "Veterans' Administration Health-Care Programs Improvement Act of 1985".

We will also discuss S. 6, the proposed "Veterans' Administration Health-Care Amendments of 1985", and amendment No. 22 to S. 6 which were introduced by Senator Cranston, the distinguished ranking minority member of the committee. S. 1007, the proposed "Veterans' Health Care Promotion Act of 1985" introduced by Senators Boschwitz and Denton, and S. 1052, the proposed "Veterans' Chiropractic Services Demonstration Projects Act of 1985" introduced by Senators Thurmond and DeConcini.

There is one central theme that the committee has been addressing since the beginning of this session. It is one which is the basis for many of the provisions we are going to discuss today. The health and mental health needs of veterans are changing. The VA health-care system is changing.

These changes are a result of various factors and events. First, the World War II veteran population is graying and the Vietnam veteran population is maturing. Second, medical knowledge, technology and practice are advancing at a rapid rate. Third, a wiser variety of health-care services are being offered on an outpatient basis and at home; and fourth, health-care cost-containment efforts are being developed and applied.

It is essential that we not only recognize these changes but act in a responsible manner to adequately address the changing needs of veterans. We must plan for these changes in a systematic and objective way. And Congress must provide the VA with the flexibility to adapt to these changes.

That, in fact, is the intent of many of the provisions today before the committee. It is not the intent of the committee to, in any way, reduce or alter the VA's mission with regard to health care. It is important, however, for the VA to have the authority to initiate plans which would address changes in veterans' needs.

And so, we will hear this morning from a fine group of witnesses. Included are representatives from the VA, the American Psychiatric Association, the General Accounting Office, the American Psychological Association, and the National Association of Social

Workers. Representatives from The American Legion, Veterans of Foreign Wars, the Disabled American Veterans, AMVETS, the Paralyzed Veterans of America, and the Vietnam Veterans of America will provide us with the benefit of their insight on these important legislative proposals.

I look forward to receiving their views. Due to the large number of witnesses, I regret that the oral testimony will be limited to 5 minutes. I thank the witnesses in advance for their cooperation.

[Veterans' Administration's witnesses' testimony resumed.]

Chariman **Murkowski**. All right. What's next?

Mr. **Principi**. In view of the ongoing Senate consideration of the first concurrent resolution, the committee markup scheduled for this Thursday, May 9, has been postponed and will be rescheduled. There is a possibility that on this Thursday, May 9, we may be able to consider the nomination of Mr. Donald Shasteen to be the Assistant Secretary of Labor for Veterans Employment and Training, and we shall have final word on that issue later today.

Chairman **Murkowski**. Senator Cranston, do you have any questions?

Senator **Cranston**. Yes, I do have some questions, Mr. Chairman.

On pages 20 and 21 of your statement you discuss section 4 of S. 6 which would extend the Public Law 97-72, health care eligibility for veterans exposed either to dioxin or other toxic substances in Vietnam or to ionizing radiation for nuclear detonation.

Although your statement appears to agree with our reason for proposing the extension; namely, that the major epidemiological study of veterans exposed to dioxin will not be sufficiently finished by 1987 to permit a final decision to be made regarding ongoing eligibility for these veterans to receive VA health care, you never actually indicate for formal position for or against the extension. What is the agency's actual position on the extension?

Dr. **Gronvall**. Yes, we have no objection to enactment of an extension. That was inadvertently left out. The final sentence of that paragraph describes the benefits of the proposed extension and we should have made that more clear.

Thank you, Senator.

Senator **Cranston**. Thank you. In commenting on section 7 of S. 6, the statement raises concerns about single provider programs. How many surgical specialty staffs are there in the VA which have only a single physician? I'm asking about specialties.

Dr. **Brown**. Senator, I don't have the exact number of programs that are operated by one, but as you know, the one that's most recently in the press is cardiac surgery and most of our cardiac surgery programs have but one cardiac surgeon on the hospital staff.

Senator **Cranston**. Let me get this for the record. When could you do that? How soon could you do that?

Dr. **Brown**. Yes, sir, I would think that we could have that within a week or so.

Senator **Cranston**. Thank you.

[Subsequently, the Veterans' Administration submitted the following information:]

There are 250 surgical specialty programs within the VA which have only a single staff physician, full- or part-time.

Of the 135 facilities with a surgical program, 113 of these facilities have at least one surgical specialty which has only one staff surgeon. The breakdown by specialty of these 250 surgical specialties that have only a single staff surgeon is:

Anesthesiology	16
General surgery	8
Gynecology	8
Neurosurgery	22
Oncology	2
Ophthalmology	24
Orthopedics	29
Otorhinolaryngology	24
Plastic and maxillo facial	28
Proctology	3
Thoracic	37
Urology	49
Total	250

Senator **Cranston**. On page 23 of the statement it stated that the VA believes, "That an individual patient should be apprised of mortality and morbidity statistics as they relate to his or her own care."

Does this mean that the agency supports disclosure of a single physician's mortality and morbidity data to an individual veteran?

Dr. **Brown**. I will go ahead and take that.

Yes, sir, it does, and as a matter of fact, as a part of the informed consent that is routinely done. The mortality and the expectations for that particular patient, as well as the general mortality statistics, are discussed.

Senator **Cranston**. So, that you're giving the particular mortality and morbidity data that the VA has to that veteran?

Dr. **Brown**. I'm sorry. I didn't understand the——

Senator **Cranston**. Well, is the individual veteran given the mortality and morbidity data that the VA has for that procedure?

Dr. **Brown**. Yes, sir.

Senator **Cranston**. Is a veteran who is given such information advised against any redisclosure?

Dr. **Brown**. No; he is not.

Senator **Cranston**. Why not? I believe it's prohibited by law, is it not, to redisclose?

Dr. **Brown**. I'll ask Assistant General Counsel to comment on that.

Mr. **Hendricks**. I think there is a prohibition against disclosure publicly. It is my understanding that as part of the process of informed consent the patient needs to be fully apprised of the risks of the procedure, and I think it may or may not include those statistics. I think it's an individual decision.

Senator **Cranston**. The law prohibits any redisclosure of confidential information so I should think you'd be advising the veterans that they're not supposed to disclose the information.

Mr. **Hendricks**. Yes; but what I'm also trying to say is it's not clear to me that those statistics are always disclosed. I think it's more likely, Dr. Brown, that if the patient asks——

Senator **Cranston**. Dr. Brown said they were.

Mr. **Hendricks**. We probably have had a communication glich because in our discussions we were told that it's not always the case. The key issue here is informed consent. So, the patient does know the risks of the procedure he's contemplating.

Senator **Cranston**. That's not really the patient's risk that I'm pursuing now. I'm pursuing the business of getting those figures out to the public, and the law indicates that's not supposed to happen. It prohibits it.

Dr. **Brown**. I'm confident that we do not——

Senator **Cranston**. Well, would you explore this for the record and reply back to us. You know what I'm driving at?

Dr. **Brown**. Yes, sir.

Senator **Cranston**. And, cite what regulation provides for disclosure to the veteran.

[Subsequently, the Veterans' Administration submitted the following information:]

In response to the question "Does this mean that the Agency supports disclosure of . . . mortality and morbidity data to an individual veteran" Dr. Brown stated "Yes, sir, it does, and as a matter of fact, as a part of the informed consent that [disclosure] is routinely done. The mortality and the expectations for that particular patient, as well as the general mortality statistics are discussed." In the context of Senator Cranston's followup questions on this matter, Dr. Brown and Mr. Hendricks did not have sufficient time to provide a complete explanation of informed consent as it relates to the disclosure of mortality and morbidity information and confidentiality.

Informed consent means that a patient is provided with a clear, concise explanation of his or her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success.

In explaining possible risks and complications to a VA patient the VA physician or surgeon often will discuss pertinent information about mortality and morbidity statistics which are specific to that patient's disease, condition, age, and other related factors. The provider should make known to the patient his or her own clinical experience, not limited to the VA, in performing the procedures. This information is predicated on the provider's own independent knowledge and not solely on one set of statistics generated by the VA's quality assurance program.

Therefore, in discussing with a patient the potential mortality and complication risks from a proposed procedure a VA provider would disclose information which is not confidential.

Senator **Cranston**. How do you reconcile this position on providing data to an individual veteran with the position set forth on page 24 of your statement that, "Statistical data could easily be misinterpreted by the veteran."

Dr. **Brown**. Well, I think when we are asking the patient to consent to a surgical procedure that patient has a right to know all the risks involved in that particular surgical procedure and, therefore, the surgeon is there to explain in detail what the risks are and all the ramifications of that and to insure that the patient understands that.

We do not have that opportunity, as you know when we are releasing publicly general data.

Senator **Cranston**. Well, why couldn't you explain the data at the same time that it's released?

Dr. **Brown**. Well, we've attempted to do that in the recent case with Miami Cardiac Surgery Program. As a matter of fact we took great pains to explain that, but it never arrived in the publications that were seen in the press.

Senator **Cranston**. On page 24 of your statement you note a concern that, "Surgical mortality rates may become a public indicia for accessing the care of a facility."

That expression of concern would seem to suggest that the agency really opposes releasing any aggregate data, even those data that would not identify any patient or physician, directly or indirectly.

Do I understand the sentence correctly?

Dr. **Brown**. No, sir. We do release general data that's not physician or team specific and we had released the aggregated data.

Senator **Cranston**. Your statement really refers to categorical statement across the board. I'm not really clear on it, on this situation.

Well, let's go on. On page 23 you state that disclosure or mortality and morbidity data, "will in fact significantly influence the mortality and morbidity statistics reported in small single provider programs."

Do you mean to suggest by that that if such disclosure were potentially available the VA would be unable through appropriate quality assurance activities to ensure that morbidity and mortality data are reported correctly?

Dr. **Brown**. I think the most important factor, Senator, is that we preserve the peer review process, as you mentioned in your opening statement, and I would not like any disclosure to conflict with that peer review.

Yes, I'm afraid it might disturb the reporting of mortality statistics. For example, if a patient has intercurrent pneumonia, I think it would be very tempting for the treatment team to attribute the death to pneumonia rather than the surgical procedure even though that's a complication of the surgical procedure.

So, I think it's subject to that type of manipulation without the peer review which looks at the entire patient and all the patients' illnesses and decides what the factors are that contributed to the patient's mortality or morbidity.

Senator **Cranston**. Well, thank you. I'd like to submit some more questions in writing on that subject.

I have a number—several questions regarding my proposal on section 8 of S. 6 to provide the disciplinary proceedings under section 4110 of title 38 would apply in cases involving proposed reductions or revocations of the clinical privileges of title 38 personnel.

Does there exist under current law a regulation that would guarantee that an individual VA employee facing a reduction or revocation of clinical privileges would be permitted, one, to be present at all proceedings; two, to hear and confront witnesses testifying in support of such action; three, to have a transcript of all proceedings so as to be able to prepare an appeal; and, four, to have an attorney present to represent him or her.

Dr. **Brown**. Senator, there is a review process in each hospital for clinical privileges, particularly—you're talking specifically about the revocation of clinical privileges. That person has a right to be heard by a board of peers—in this case, if it were a physician, there would be a board of physicians. That person has a right to appeal to an ad hoc committee who has been designated to hear the case. They can bring a lawyer. They can cross-examine witnesses. And, then, further, if they're not satisfied with that hearing, they can appeal to the Director of the hospital, and further, can appeal to central office.

Senator **Cranston**. Is a transcript of the proceedings made available?

Dr. **Brown**. I don't know whether that's accurate or not. Not necessarily.

Senator **Cranston**. Well, what about the opportunity to hear and confront witnesses?

Dr. **Brown**. Yes, sir, that opportunity is there, and as a matter of fact, when this has been reviewed in district court they have upheld the proceedings and said that it does protect the individual's rights.

Senator **Cranston**. Does the individual have the right to be present at all times during proceedings?

Dr. **Brown**. Yes.

Senator **Cranston**. What grounds under current law and regulation, other than inaptitude, inefficiency or misconduct, would be the basis for restricting or removing an individual's clinical privileges?

Dr. **Brown**. The grounds would be primarily to protect patients. The clinical privileges are granted according to an individual's experience and ability. When a physician joins a hospital he makes application to the hospital for certain privileges. If it's a surgeon, for example, he has to furnish documents to the effect that he is skilled in certain procedures, and after review, he's granted those privileges.

If there is question about that person's ability to perform certain procedures, if there are untoward events that need to be investigated, for example, it's important to be able to withdraw those clinical privileges at least until it's ascertained whether or not that person has that skill.

Senator **Cranston**. Does the VA have authority under section 4110 and its regulation to remove a health-care professional from contact with patients during the pendency of disciplinary proceedings when it is determined necessary to protect the patient?

Dr. **Brown**. Mr. Hendricks, can you help me with that?

Mr. **Hendricks**. The VA has authority, Senator, but we don't believe it falls under section 4110. We think there is administrative authority to direct a physician or employ to do certain activities.

Section 4110 provides for a hearing for the disciplinary proceedings and, as a matter of law, the hearing must occur before the penalty assessed under section 4110 takes place.

Senator **Cranston**. Would that same authority apply to the proposal that I'm making?

Mr. **Hendricks**. Yes, we believe it would.

Senator **Cranston**. OK. Thank you very much.

Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you very much, Senator Cranston. I believe Senator Mitchell joined us next. Do you have a statement you would like to enter in the record?

Senator **Mitchell**. Yes, I do, Mr. Chairman. In the interests of time I won't read the statement. I will ask that it be inserted in the record.

Chairman **MURKOWSKI**. It will be entered in the record.

[The prepared statement on Hon. George J. Mitchell, a U.S. Senator From the State of Maine, follows:]

PREPARED STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

I welcome the witnesses to this morning's hearings on legislation relating to Veterans' Administration health-care services. In the present fiscal year, the VA's medical programs are funded at roughly $9 billion, a figure which constitutes 35 percent of the total VA budget.

The VA's health-care system, encompassing 172 medical centers, nursing homes, outpatient clinics and other facilities and 190,000 full-time equivalent employees is the largest in the country and provides a valuable and necessary service to this Nation's 28 million veterans.

In fulfilling its oversight responsibilities, this Committee must cast a critical eye at the panoply of health-care services provided to our Nation's eligible veterans to ensure that those veterans are provided the health care they deserve in a manner which makes the maximum utilization of the VA's personnel and facility resources.

There are a number of bills before the Committee today which would affect a wide range of VA health-care programs and authorities. I am a cosponsor of one of the bills, S. 6, introduced by the distinguished ranking member, Senator Cranston.

I look forward to receiving the testimony of today's witnesses on all measures before the Committee, although I apologize in advance for not being able to stay for the entire hearing. I will review the written testimony carefully.

I also look forward to working with the Chairman, the ranking member, and the other members of the Committee in crafting a health-care bill again this year that addresses the present inefficiencies or deficiences in the VA's health-care system.

Chairman **MURKOWSKI**. Senator Specter.

Senator **SPECTER**. Thank you, Mr. Chairman. I, too, have an opening statement which I'd ask to have inserted in the record and in the interest of time would like to submit a series of questions for the record.

And, I must proceed to the Juvenile Justice Subcommittee which I'm due to chair, actually about now. So, if these might be inserted in the record and the questions submitted for the record I would very much appreciate it.

Chairman **MURKOWSKI**. This statement will be entered into the record.

[The prepared statement of Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania, follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I congratulate you on your ambitious hearing and markup schedule, and for bringing this important health-care legislation before the Committee.

I thank our witnesses and panels for their written testimony and for appearing here this morning. I particularly appreciate the representatives of the veterans' organizations for consistently providing your extremely helpful and thoughtful viewpoints.

Today's agenda offers a wide range of veterans health-care legislation initiatives, however, it is my sense that there is a common thread running through each bill and hopefully through all our efforts in this Committee. That thread is our strong need and desire to provide improved and expanded services to a large number of veterans, in the most appropriate setting, and with a maximum use of resources.

I congratulate my colleagues for introducing the legislation before us, and I will carefully consider it in the context of our guests' testimony.

Mr. Chairman, the provision of quality health care to our Nation's veterans remains a high priority for me.

Senator **MITCHELL**. Is this the appropriate time for questions? I didn't know——

Chairman **Murkowski**. No, I'm just going to move around.

I believe Senator Boschwitz is next.

Senator **Boschwitz**. Mr. Chairman, I, too, have a longer opening statement that I ask be submitted for the record, but it's again a pleasure to be here this morning and listen to the testimony of the VA and also major veterans' organizations.

Like you, I'm most interested in hearing their views on various health-care proposals and I hope that today's hearing will be constructive and thorough.

I must note at the outset, Mr. Chairman, that I'm disappointed that the VA has not yet responded to some questions I submitted on March 27, at the construction hearing held here. I asked two questions concerning the VA's policy toward acquisition of existing facilities. Specifically, I asked if its policy was, as Dr. Gronvall stated, namely that the VA does pursue the policy of acquiring facilities and if so did they have any current plans to do so. Secondly, which areas of the country that currently were on the VA's replacement list could potentially use this option and was the VA taking the first steps of contacting local officials to see if this option was feasible.

The option, Mr. Chairman, that I'm talking about is of course incorporated in the bill that Senator Denton and myself plus Pressler and Heflin have introduced and that's also been introduced on the House side, which would be a step towards seeing whether or not the nursing home and other type of VA facilities could be leased and perhaps privately operated, as well as operated by the VA.

I understand that some of the veterans' organizations who support this idea in concept are concerned about whether or not this bill is an effort, or a first step toward mainstreaming. That's not the purpose. The purpose is to understand the problem that will be arising in the coming years as the Second World War vets get into the retirement stage of their life and many of them seek nursing home care. So, rather than building a large number of such facilities and then find them empty as these veterans leave them, we have introduced some legislation that would on a trial basis explore options.

Our bill includes a pilot provision to have facilities that are leased and perhaps privately operated or built privately and VA operated or one of the two or both. And, we have done so on the basis of a trial here and there—a pilot project, so to speak—because perhaps a case can indeed be made that the VA facilities have different requirements and different needs than do normal medical facilities.

I note in the long testimony the VA is giving this morning, that they don't make meaningful reference to this bill and I understand this is because they haven't yet completed their study of it. So I look forward to reviewing such evaluation when it is completed, because the legislation really is meant in the best of face, and it's not meant to change the nature of the VA, but to recognize a problem that's going to be coming on in the years that are not far ahead and that constructing facilities by the VA has been expensive.

And, while those facilities, if they become empty, could be disposed of in later years, the Government is not particularly good at disposing of facilities, so usually there are costs on the front and on the rear end. These are things that we could possibly avoid if we lease or purchase existing facilities and yet we can still provide the kind of care that veterans are entitled to and that we expect them to receive.

So, thank you, Mr. Chairman, and my longer statement—longer even than the opening statement—I submit for the record.

Chairman MURKOWSKI. Your longer statement will be entered into the record and we appreciate your brevity. I understand that you have questions for the record as well that will be addressed.

Senator BOSCHWITZ. I may have some questions for the record as the testimony proceeds, and I do have a couple of other submittals.

[The prepared statement of Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota, follows:]

PREPARED STATEMENT OF HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Mr. Chairman, the roots of this legislation are long -- stretching back to nearly 1980 when I became involved in trying to provide funds for a replacement hospital for the aged and outdated Minneapolis Veterans Hospital.

Those battles with the VA over its constantly changing priority list, and the parallel battles with certain local groups over the lack of need for a replacement facility because local hospital beds were unused, laid the groundwork for my continuing interest in vets health care and the VA's construction process.

Mr. Chairman, since those days in 1980 the VA has spent $2.7 billion on the construction of new or replacement medical facilities. This year the Administration's budget calls for an additional $2.5 billion over the next three years. And this is really just the tip of the iceberg. CBO projects that $400 million will be needed over the next five years just to meet the new construction needs for nursing homes.

However, if the VA attempts to retain its current level of providing nursing home beds, the costs would go up an additional $200 million. And this is just for nursing homes.

Currently the VA provides 40 percent of the veterans nursing home beds, the state home program provides 20 percent, and the remaining 40 percent are contracted on an individual basis to non-VA nursing homes.

However, in addition to nursing home spending, CBO estimates that the funds needed for the replacement or modernization of existing VA hospitals could cost as much as $2.9 billion.

Unfortunately, the VA's construction process is at least twice as expensive as the private sector. This means that while we are doing what we can to see that the veterans of this country are getting the health care they deserve, we are clearly not getting as much bang our the buck as we could. And in this budget cutting climate we have to stretch each dollar as wisely and as far as we can. That is why I decided to introduce my legislation. I feel that if we can cut costs in the construction area, we can provide more beds, serve more veterans, and provide better overall health care for this nation's veterans.

I realize that at first blush some may see my bill as somewhat controversial, and perhaps as a first step of some sort toward dismantling the Veterans Administration Health Care system. But it's clearly not either of these. In fact

I believe my bill gives us a unique opportunity to strengthen the VA Health Care system.

Mr. Chairman, everyone involved with veterans and the VA knows the crunch is coming. The demographics of the aging veteran have been published in every major media forum. The VA also, to its credit, has tried to address and plan for the influx of aging veterans.

If the VA is right and the demand for VA health care triples by the year 2000 -- with patient load leaping from 4.5 million today to over 12 million -- then there will be a tremendous strain on both the VA and its budget. Clearly, we want to be in a position to provide VA health care for as many eligible veterans as we can.

Therefore, we must realize that in order to pay for the care we have promised the veteran, we must develop more cost-effective methods of providing it. But we must provide it in such a way that we don't jeopardize the commitments we have made to our veterans. And we must also recognize that the VA's costs will normally be somewhat higher than the private sector because of the type of patients it serves and the dedicated mission it has been given. However, it is clear Congress and the VA must look at the options and alternatives available.

That is what the bill Senator Denton and I introduced is designed to do. First, get the VA to look at other ways to provide care before simply building a new expensive facility. Second, the bill sets up four pilot projects that will allow the VA, Congress and the veterans of this country a chance to see how these options work.

I realize that some will argue that since the VA now has the authority to acquire existing facilities that directing them to do so isn't needed. Unfortunately, it is clear that the VA has no intention of taking this course, since they, by their own admission, have never acquired even one nursing home or hospital. So if we wait for them to make the first move, it will probably be the year 2020.

That's why I believe the Mobile Alabama Register's comments are so accurate. In an editorial in support of our bill they commented:

> "The legislation is akin to hitting a
> mule between the eyes with a
> two-by-four to catch his attention.

Mr. Chairman, basically our legislation does three things.

(1) It requires that the VA's first option when developing plans for new or replacement medical facilities shall be to consider leasing or purchasing existing community facilities. As I mentioned, the VA has the authority now to lease or acquire existing facilities, but it has never used it for either hospitals or nursing homes.

(2) Sets up a pilot program to look at four different scenarios. The first would be a privately built, privately run nursing homes that the VA would contract eligible veterans to in a five year agreement. Veterans in my state of Minnesota support such a pilot project located in Grand Rapids, Minnesota. In this case, a veteran would like to build a nursing home facility for vets and then run it with his staff.

The second would be a nursing home that was privately planned, designed and built that would then be leased to the VA and run by the VA. This nursing home would then revert to the private sector when no longer needed by the VA.

The third would require the VA to purchase an existing medical facility. It seems that a perfect opportunity to exercise this option is available in Mobile, Alabama where the VA can acquire a hospital for $25 million, and in fact the purchase option has been looked at by the VA and the local community. In contrast, the replacement Minneapolis hospital I fought so hard and successfully to get funded cost over $200 million.

The fourth option would be for the VA to simply lease an existing facility.

(3) The bill also requires the VA to report on the potential cost savings of increasing the number of nursing home beds contracted to community facilities. As I mentioned earlier, the VA has a 40 percent share of the veteran nursing home beds, as do community contracts. The bill asks the VA to look at increasing the community share to 60 percent or 75 percent.

Mr. Chairman, this provision was included in the bill primarily because of a survey I mailed to over 60,000 Minnesota vets last summer asking for their views on how Congress should fund the number of nursing home beds that will be needed by the year 2000. The results were somewhat startling with 73.4 percent of the respondents saying that the VA should not build more nursing homes. Overall, the results reemphasized my belief that veterans are concerned both about available health care and cost-effective care.

Mr. Chairman, I hope my colleagues will agree that the time is right to look at a different ways to spend our VA construction money. The crunch is certainly coming. If we can get started now, maybe we can do more than just wring our hands when the time comes.

I also hope my colleagues on this Committee will join me in working with the VA, and the veterans groups in working with this bill to improve it, and then seeing it made into law.

Chairman **Murkowski**. I know that Senator Mitchell has to be excused. But before he leaves, I think that he has some questions that he may wish to ask. I would like to note for posterity and prosperity the reality that today marks the official end, 10 years ago of the Vietnam war. I am sure that we are all aware of that.

We join with millions of other Americans who are grateful for the contribution of the Vietnam veterans. I want to express our profound thanks and indebtedness to those soldiers as we mark this significant event. Senator Mitchell.

Senator **Mitchell**. Thank you, Mr. Chairman. I have to go to a Finance Committee markup. I have a series of questions. I would like to ask just one, and then I will submit the remainder for the record.

Chairman **Murkowski**. We appreciate that. We have a long list of witnesses today.

Senator **Mitchell**. I know that the other Senators have questions. I would like to just ask one question.

As I understand it, the VA opposes making permanent its authority to contract with non-VA halfway houses or other community based programs for treatment of eligible veterans suffering alcohol or drug abuse dependencies. The VA does, however, support a 3-year extension of the authority.

Now has the authority proved beneficial to the VA and the eligible veterans; and if so, what is the basis for supporting an extension of this program, but opposing making it permanent?

Dr. **Gronvall**. Dr. Brown will comment on that.

Dr. **Brown**. Senator, we are impressed initially with the benefit of the program. However, the data that we have collected is simply based on 9 months of experience. And we would feel that it would be better to accumulate more detailed proof before we ask that it be made permanent.

And in the meanwhile, we would like to extend the program, because we are convinced, as is detailed in our statement, that it is an excellent program which is of benefit to veterans.

Senator **Mitchell**. Thank you very much. Thank you, Mr. Chairman. And I will give my other questions to the staff to be submitted in writing.

Chairman **Murkowski**. Thank you very much, Senator Mitchell.

Gentlemen, I am a bit concerned about the position of the VA on section 2 of S. 876 relating to noninstitutional services. I have a number of references here, "Caring for the Older Veteran," the Administrator's Digest, where the VA acknowledges that the greatest challenge that it has ever faced is that of meeting the needs of the increasing number of aging veterans.

Do you agree with that?

Dr. **Gronvall**. Yes, sir.

Chairman **Murkowski**. And a statement in the VA's report "Caring for the Older Veteran," reads:

> Noninstitutional extended care has not been exclusively available in the VA system to date.

Well, we are aware of that.

> The overall goals of the VA health program for its beneficiaries will not change as a result of the aging or of its population.

And then we get statements relative to the need for innovation. And I am just wondering. It seems to me that testimony has been given before the committee that the VA has not had the availability of adequate planning to meet these growing needs, nor is the likelihood of adequate funding going to be available on time.

And as a consequence, I guess that I would like to hear what you expect to do about the dilemma that you are facing as you seem to eliminate some of the alternatives that appear to be before you.

Dr. GRONVALL. Let me make some general comments that respond to your concern. I think that as one surveys the health system of the country, both Federal and non-Federal, it is uniformly the observation of reviewers that the whole health system is not adequately prepared to deal with the many issues that relate to an aging population.

The Veterans' Administration, I believe, is regularly reviewed by those from outside of the Government as having established a leadership position in the country in both planning for medical and other needs of older veterans, and in fact in taking the lead to initiate pilot projects, demonstration programs, research into aging, a search for new solutions, both to prevent illness and prevent the problems that relate to aging, and deal with the consequences of aging.

So as a generalization, even though I think that it is apparent that the country is not adequately prepared as you look at the various parts of the health system, that the VA is usually judged by independent observers to have a leadership position.

The report, "Caring for the Older Veteran," represented an organized attempt. It was not the first planning document prepared or released by the VA dealing with issues of aging. It represented a comprehensive effort to document from the VA perspective what the need was going to be over the next several decades.

It was released with the specific intent of engendering the kind of debate and discussion that has gone on in this committee and other committees in the veterans' service organizations and in the health disciplines and the health sector of the country.

In that general way, Mr. Chairman, I think that we are eager participants in this debate with the expectation that over the course of this year, the report itself projected a timetable of some 18 months during which the Nation could test the assumptions that were prepared in the report, independently evaluate them, come to some kind of consensus about what that need was going to be and how great it was going to be, following which the necessary programmatic commitments and resource commitments could be put in place to begin dealing with it.

Chairman MURKOWSKI. Well, Doctor, my question specifically is that it appears that the timeframe that the VA works under to develop an idea into reality is 5 to 8 years. Now if that is true, then we have figures that indicate that the peak need of the Second World War veterans requiring care for the aged is going to come in in about 1990, and peak in the year 2000. And then it will drop down.

I have figures that indicate that in 1990, it will be about 7 million. And in the year 2000, it will be 9 million. And then it will drop.

Now if you work on a 5- to 8-year planning to reality schedule, are we still going to be studying this issue in 1990?

Dr. **Gronvall**. I believe that there will be studies going on.

Chairman **Murkowski**. Studies are not going to provide the care.

Dr. **Gronvall**. I believe that the plans that the VA has and has put forward for facilities—for example, the establishment of additional hospitals in Florida; the construction plans for renovations and alterations of existing facilities; the construction proposals for nursing homes; the various research proposals that have been established and funded; and the establishment of geriatric evaluation clinical centers, research and evaluation clinical centers.

All of those represent tangible plans converted into actual programs placed before the Congress.

Chairman **Murkowski**. Do you really think that those programs are going to be adequate to meet this tremendous requirement of people who are in that age group with the three or four hospitals that we are building each year around the country and the nursing homes? I was led to believe that it would be totally inadequate.

Dr. **Gronvall**. It is my judgment that the maximum peak need as projected in the aging report would not be met by the plans that have currently been approved and established by the VA.

Chairman **Murkowski**. All right, so we cannot meet the need then under the plan that has been approved by the VA?

Dr. **Gronvall**. Cannot meet all of the need.

Chairman **Murkowski**. What percentage of the need can we meet?

Dr. **Gronvall**. I think to answer that would require a definition of what level of need you believe to be the most accurate projection. The report intentionally attempted to portray the need in a number of different ways by stating a number of basic assumptions that would support the projection of what the need would be.

Chairman **Murkowski**. But if we cannot even identify the percentage of the need that we probably will have the capacity to meet, how can we possibly address the issue we are faced with. You have to clarify one percentage or the other.

Dr. **Gronvall**. I think that it is not in fact possible to select one specific projection or one specific set of projections, and say that is the need period.

Chairman **Murkowski**. All right. I would disagree with you, but you have to be prepared for that demand somehow. If you cannot identify specifically what it is, then you try and provide some alternative so that you can handle it, and at least address the needs. And that is why I wonder why you oppose this pilot program to allow elderly and disabled veterans to live at home instead of in a nursing home, especially since we cannot quantify just what the total need is.

This at least would have an ongoing program and would offer the safeguards of being prepared to do something. And it seems to me while perhaps it is justifiable that you are opposed to this concept, then what do you support?

Dr. **Gronvall**. I think that both in our testimony here today and in other places that we have strongly supported the general concept that means should be sought to assist veterans to avoid the need for hospital care or nursing home care. Our nonsupport of the specific proposal before us today involves a matter of narrow judgment about the extent to which the specific piece of legislation would further that concept or not.

Our testimony says that we clearly support the concept, and suggest that we would be anxious to work with the committee. We hope to perfect means that would accomplish that goal in a more effective way.

One additional comment might be made on that. The comment in our testimony is in the context also of the existing VA budget where new measures must be judged against existing measures in terms of the resources available.

Chairman **MURKOWSKI**. You state that you oppose S. 875, the proposed Vietnam Veteran Resource Centers Act because it would move Vet Centers in the direction of self-contained systems. Yet on the other hand, you state that certain Vet Centers are unofficially providing the same services and resources which would be mandated by the proposed legislation, job counseling, benefit counseling, drug and alcohol abuse, and so forth.

You do not oppose providing these services, I gather, at Vet Centers as long as it is done unofficially. But you apparently oppose doing so on an official basis when the results could be measured. I do not understand the inconsistency in your testimony.

Dr. **GRONVALL**. Well, let me ask Dr. Brown to comment.

Dr. **BROWN**. We are supporting the present programs as they exist. We are not asking that they hide anything from us. We support the fact that 125 Vet Centers have Department of Labor representation and are assisting in this way.

Our point is that we feel that we are doing many of these things now, and that we are doing it in a cost-effective and efficient manner. In providing services, we have the Department of Labor representative come over to 125 Vet Centers, and we arrange referrals to the regional offices when appropriate and referrals to drug and alcohol clinics when appropriate.

Or if the talent exists within our Vet Centers to treat drug and alcohol abuse, we of course offer what we can there. But our staffs also recognize, for example, with drug and alcohol that the best treatment facilities are in an established program, and therefore make the referrals when appropriate.

Chairman **MURKOWSKI**. What specifically do you object to in the proposed Vet Centers the way that they are currently run?

Dr. **BROWN**. The way that they are currently run?

Chairman **MURKOWSKI**. Yes.

Dr. **BROWN**. I have no objection to the way that they are currently run.

Chairman **MURKOWSKI**. Well, under the proposed legislation, the way that they will be run, I guess is what you object to.

Dr. **BROWN**. Yes, sir. We oppose the legislation in part because we feel that it would require an expansion of both the capability and also the staffing. I think that it would be expensive. For example, we projected that it would require an additional six FTE's for each of the 10 sites, and the total bill would be somewhere just under $3 million, $2.7 million, because we would have to expand.

Chairman **MURKOWSKI**. Where would you get these services? Is there a need for them?

Dr. BROWN. Yes, sir.

Chairman MURKOWSKI. If you do not provide them, then what happens?

Dr. GRONVALL. Now we refer them to the drug and alcohol clinic, for example, if that is appropriate. I have visited a number of our drug and alcohol clinics. They uniformly tell me that they are very busy now. That they really do not have access personnel to transfer over to Vet Centers. They are fully committed now. And it is best to refer these people to an established program, because that is where they get the best treatment.

Chairman MURKOWSKI. Well, I guess that my concern is how marginal availability and accessibility, which is what the centers offer, compares to providing specialized treatment. Perhaps something is better than nothing, but how many eligible veterans are going to avail themselves of the specialized care that is not as readily available as marginal care in a local Vet Center?

Dr. BROWN. Mr. Chairman, I do not regard the care that we are providing in our Vet Centers as marginal. I think that the people who are stafffing our Vet Centers are fully capable of assessing the need of a veteran. And if they cannot provide for whatever is required where the Vet Center is located, they are not hesitant to refer to whatever source can meet the need: the regional office, VA hospital, or community resource.

Chairman MURKOWSKI. Then I am lost again as to why you object to the proposal.

Dr. BROWN. I just do not think that it is necessary.

Chairman MURKOWSKI. If we do not have it in the Vet Center, then the individual veteran that has the problem is going to have to get it from the specialized treatment center at a VA hospital, is that not correct?

Dr. BROWN. Yes, sir, or a drug and alcohol clinic.

Chairman MURKOWSKI. Does not the Vet Center now work on kind of a referral basis. That they try to do as much rehabilitation as they can. If they have a case that requires specialized care, they refer it to the VA hospital where they have that capability.

Dr. BROWN. Yes, sir. But the referrals are both ways. We recognize that the Vet Centers have special capability and special training. And therefore, there are referrals in both directions. The clinics and hospitals refer to the Vet Centers for appropriate counseling.

Chairman MURKOWSKI. Well, it would seem to me that the Vet Centers are somewhat limited, because of their staffing. If you have an established drug or alcohol rehabilitation center in association with a VA hospital, the quality of that care ordinarily would be probably much higher than you'd get in a Vet Center.

Dr. BROWN. Yes, sir.

Chairman MURKOWSKI. So, I still don't see why trying to do what they can to assist in the Vet Center, and then for those which require the specialized care, refer them to what's available, why that can't work.

Dr. BROWN. Mr. Chairman, I think what I'm saying is that's happening now. They provide what care they can. If there are psychologists and social workers in the Vet Center who are especially skilled in drug and alcohol treatment, they will provide that counseling.

If it goes beyond their capability, they refer to the experts.

Chairman **Murkowski**. Well, I think what the Vet Centers were designed to do is to be an outreach of the VA services, and I guess we could debate all day the realities of whether those in rural areas have the availablility of the specialized services that are available through the established VA hospitals and their associated expertise.

So, you know, there's a lot of areas outside the areas where the hospitals provide a geographical capability. We've got a list here of about 17 specific concerns expressed by veterans in the utilization of the Vet Centers, and utilization appears to be quite good.

I'm not going to pursue this, because obviously, you know, you have your point of view, and I don't dispute it. It just seems to me that we're kind of tracking the same basis, and we have very little difference. I would like to get back and conclude a little more questioning on one specific area.

And that is how we are going to take care of the aged veteran. We study it and write books about it. But when it comes down to putting it in an understandable statement so that I can respond to the various veterans' organizations and they can tell me, or somebody can say "Here's what we've got positively going," it gets kind of fuzzy.

And somebody says,

> Well, we just are way behind the curve on the realities associated with meeting this demand, whether it be funding, planning and on and on. We don't know how many veterans we're going to have to care for. We know when the peaks are going to be, but we've discussed it and we're going to study it some more, and so forth.

But at some point in time somebody's going to have to do something that you can physically see. We're going to have to vote more facilities and get more money, we're going to have to contract. Now, I'm a bottom-line guy, and, you know, I believe obviously you have to make judgments on the best information available, which means you have to study and evaluate it.

But you also have to make decisions. The VA's coming to me and saying "You know, we are 5 years behind in our planning." There's a qualification there. "Well, we don't know what we're exactly going to need," and so forth and so on.

When are we going to get down to the gut issue of whether we're going to meet the demand or not, through one method or another, or a combination of both?

Dr. **Gronvall**. I'll make a couple of comments to that. I believe that for the past 10 years at least the issue of moving the healthcare system of the VA in the direction of being able to respond to the needs of older veterans has been a primary factor that has conditioned our recommendations and requests for establishment of new hospitals, for major renovations and projects in existing hospitals——

Chairman **Murkowski**. Let me interrupt you. Why do you continue to refer to more hospitals as opposed to other facilities or options to take care of the aged, which are not necessarily hospitals?

Dr. **Gronvall**. I hadn't finished the list of items that I was going to describe. The establishment of geriatric research and education clinical centers, which represents the specific research and education clinical care thrust for aging, the establishment of additional nursing homes in the VA, the stimulus and establishment of additional State homes through the State Home Program, an expanded number of community nursing home facilities in which contract care for veterans is given, all represent tangible steps that the VA has taken to expand the array of health and medical services available, specifically geared to the array of medical problems faced by older veterans.

While that has been going on, we have attempted several times, and the most recent one was in the report that you describe, to take a global view of that issue, try to project it forward several decades, using a set of assumptions to try to target what the maximum peak of that demand would be.

It's our view that that is the responsible thing for the VA to do, and that it is then up to the Congress ultimately to decide which of those projections it most believes will represent the true need, following which additional plans could be put into place to specifically respond to it.

I do not believe that the VA has only studied this program or issue. I believe that specific programs, facilities, plans, sharing agreements, have been adopted both within the VA and in concert with the private sector and the remainder of the health field directly to meet this need.

The fact that the aggregate amount of that effort may fall short of a peak projection is a fact, but that is the reason why the report and the debate that it has engendered is important.

Chairman **MURKOWSKI**. Your comments seem to center more around the medical service area, and obviously the veterans also need health-related services, home health, personal care. The realities of health care in the United States are changing.

And these are areas that we don't necessarily focus on in our discussion. We focus on the more critical care services, as opposed to nonmedical services associated with aging, services for which I would perceive to have a larger demand.

Dr. **GRONVALL**. We have established actual programs of the sort that you're describing, hospital-based home care, adult day hospital care. Those do have a medical aspect to them, and the reason for that is that the Department of Medicine and Surgery has a medical mandate or mission established by the Congress.

Other parts of the Veterans' Administration through the Department of Veterans' Benefits do provide support that gets at the kind of social support systems you're describing. Aid and attendance allowance is a good example, where funding is provided that allows directly such social support to housebound and other impaired veterans.

Chairman **MURKOWSKI**. What is the official position of the VA with regard to the private sector providing, on a contractual basis, nonmedical services, such as home health care and personal care services?

Dr. **GRONVALL**. I don't know that I can reflect an official position, because I don't know that that question has been asked or responded to. Let me be sure I understand your question. The VA under contract with the private sector agencies to provide social support services?

Chairman **Murkowski**. Nonmedical services.

Dr. **Gronvall**. I don't believe that the VA does provide payment for such services and does not have authority to do so.

Chairman **Murkowski**. I'm aware of that. But my question, sir, is a very realistic one. If the VA isn't going to be able to provide in its hospitals, nursing homes, and domiciliaries for this demand, those veterans are going to have to be provided for in some other way.

I'm not talking about medical services now. I'm talking about the realities of growing old. Nonveterans are taken care of in homes for the aged. There's all kinds of structures throughout the United States.

Some of them are good and some of them aren't so good. Some of them are probably bad. But in any event, the process is evolving, because as you stated in your opening remarks, Doctor, this is not something that's unique to the VA.

This is a problem all over America, and we've got to relate to it. So, you know, if we're so fuzzy, and I really think we are, on what our ultimate needs are going to be, don't you think that there's reason to believe we should have some kind of a backup in the area of nonmedical-related services for the aging veteran?

Dr. **Gronvall**. I believe we do have such services, Mr. Chairman. I think Dr. John Mather is here. He's the Assistant Chief Medical Director for Geriatrics and Extended Care, and I think it would be appropriate to ask Dr. Mather to expand my comments more specifically in response to your question.

Chairman **Murkowski**. All right. I will call Dr. Mather up, but I want to keep the cohesiveness of the panel, so I will do it later.

Dr. **Gronvall**. OK.

Chairman **Murkowski**. You know, I've asked this question: I understand it's a delicate question, I understand that there are, you know, strong feelings about how care should be provided and by whom.

But I think we need a more definitive response from the VA. If the VA comes here and says,

> This is a responsibility of the VA to provide these services, and we think and forecast that we're going to need XYZ at this phase, that phase, and currently we have not only an inadequate planning fund, we have the realities of the budget process, and our ability to meet these is going to be severely curtailed unless Congress turns around and decides they're going to appropriate money.

Until we get to that point, Doctor, I don't know how we can be responsive in looking at what the alternatives are. We should either fund it through the VA or consider a combination of utilization of private sector facilities. I think we've got a problem that we're not facing up to. From the standpoint of the country as a whole, the private sector isn't going to build homes for the aged unless there's a reasonable return on the investment.

We can all get into the question of what the return is and how these firms are doing. But it's going to be more and more of a problem. If the incentive isn't there they're going to come looking to the Government to provide the incentive or guarantees.

I'm not satisfied, very frankly, with the definitive answers that I've received this morning with regard to the VA's projected needs. I would like to see something that is substantive, that we can relate to in numbers concerning the need for nonmedical services.

I'm neither satisifed nor complacent about the realities of meeting our medical needs, but at least we have a structured system that's been around for a long time and done a good job to meet the medical need.

But the nonmedical needs of the aged veteran, I think there's a real void out there.

Dr. **Gronvall**. In your comments, you've referred to homes for the aged, and——

Chairman **Murkowski**. Care for the aged.

Dr. **Gronvall**. OK, and raised a question about collaborative or cooperative arrangements with the private sector. We have no hesitancy about engaging in such arrangements. In fact, in looking at the nursing home program, of the veterans supported in nursing home care, only some 40 percent are in nursing homes built and operated by the VA.

We engage in contracts with the private sector, and work with the States through the State Home Program. Our projections for the future project continuing that collaborative arrangement. Fundamental to both that report and another one that has been produced within the past year has been the concept that the VA itself neither will be adequate to meet all these needs nor should meet them all, and that we must enter into collaborative and cooperative arrangements with the private sector to do so.

Chairman **Murkowski**. OK.

Well, here's what I think I'd like to have from you: I would like to have an analysis, based on historical data, on what your forecasts are through the year 2000 concerning what percentage of the aging veteran population is going to require medical services compared to the percentage which is going to require health-related services such as home health and personal care services.

I'm talking about, on the one hand, the anticipated demand for medical services, such as hospitals, outpatient, and nursing home care, and, on the other hand, the demand for personal noninstitutional services, both medical services and health-related services.

We know what our hospital capecities are, and we can examine the adequacy or inadequacy of it, depending on the geographical area, what facilities the VA has now, what facilities are approved and authorized for construction, and what our shortfall is going to be.

And let's assume we got a shortfall of 20,000 veterans, just as an example, coming on at such and such a time. Then the VA either builds more facilities or considers contracting out to the private sector. Whatever the figure's going to have to be, somebody's going to have to have some lead time to meet the demand.

And is there any reason why a request like that would not be of assistance to both of us? Maybe you have it. I just haven't seen it.

Dr. **Gronvall**. Let me pursue, if I might, the subdivision that you made, because you attempted to subdivide traditional health care, which I would interpret to be hospital care and outpatient clinics. That's easy.

Chairman **Murkowski**. That's correct.

Dr. **Gronvall**. But then on the other side you described home health care, and you had the word "health" in that several times, and I'm not sure exactly what you mean.

Chairman **Murkowski**. Care for the aged.

Dr. **Gronvall**. OK.

Chairman **Murkowski**. Nursing-type care.

Dr. **Gronvall**. But under that definition, care in a nursing home or care in a domiciliary would not be traditional health care as you described in the former case.

Chairman **Murkowski**. All right. Let's just take—keep it simple—take that percentage that's going to require medical care and what's left, is what we're talking about.

Dr. **Gronvall**. OK. OK.

Chairman **Murkowski**. All right?

Dr. **Gronvall**. And try to give a single best judgment from the VA's perspective about what that need would be.

Chairman **Murkowski**. Because I think the VA has the obligation to plan for that reality that's coming, and I take it we don't have that now, is that right?

Dr. **Gronvall**. We do not have a single projection that the VA has said represeents the single most——

Chairman **Murkowski**. Well, you see, Congress reacts—you see, my colleagues, they come and go, and their time is limited. There are many demands, and they relate to something that's readily understandable and a decision can be made on the basis of recommendations that are down to a simple equation in the sense of having the information and saying

> OK, we've either got to appropriate more money or we've got to look for another alternative. Here's our demands, we've got to make the decisions on that basis.

Dr. **Gronvall**. I think the VA has not shied from stepping into the fray on that issue, but we have felt that ultimately the decision about what the level of need is that the country chooses to meet is in fact a public decision, or a congressional decision, made after the kind of debate that's now going on in which the views of the service organizations, the rest of the health sector, are heard as well.

And I think the VA deliberately refrained from recommending a specific alternative proposal.

Chairman **Murkowski**. Yes, that's so. And somebody's got to have a base figure that we can agree to discuss and debate them, and that has got to be the VA, because I don't see how anybody else with any degree of accuracy can come up with that.

All right?

Dr. **Gronvall**. Yes, sir.

Chairman **Murkowski**. Thank you very much, Doctor.

Is there any other—that takes care of that, then.

We will excuse the panel.

Dr. **Gronvall**. Thank you.

Chairman **Murkowski**. Doctor, Mr. Hendricks, Dr. Brown, we wish you a good day.

I would like to have Dr. Mather; and Dr. Melvin Sabshin, medical director of the American Psychiatric Association of Washington; and Dr. Orville Lips, president of the Association of VA Chief Psychologists. That gives us three, and I will hold off on Mr. Baine.

I am sorry, Doctor; I assume that you are Dr. Mather?

Dr. **Mather**. That is correct, Mr. Chairman.

Chairman **Murkowski**. I am sorry that we do not have a sign for you. But if you get to be a regular, we will. I wonder if you have any comments that you would like to make with regard to the VA's ability to meet the needs of the aged in reference to the subjects that we were talking about earlier with Dr. Gronvall.

Dr. **Mather**. Mr. Chairman, I would be pleased to respond to your intriguing question since I think that it bears directly on the VA's Aging Report and the two major thrusts in that report that you referred to earlier. The first major thrust was, of course, an emphasis on noninstitutional care for the increasing number of aging veterans. And the second thrust was increasing cooperation with the community at large that is beyond the VA with respect to the possibility of paying for additional services, establishing quid pro quo relationships, and, further than that, increasing the amount of referral to services available in the community at large.

I would like to reiterate one policy which the Department of Medicine and Surgery has emphasized consistently, and that is the authority to provide a medical health program in which indeed we have recognized in the area of long-term care the increased need for noninstitutional alternatives.

I think that we have seen in the past 5 years the establishment and now the coming to fruition of 49 Hospital Based Home Care Programs. This committee was very instrumental a couple of years ago in seeking for us to have authority to establish medically oriented Adult Day Health Care Programs. And I am pleased to tell you that over the past couple of months, we have added five new programs and we are now up to approximately nine adult day health-care centers.

I think that you are also aware that we have had for over 30 years the authority to establish and engage in work with the community beyond the VA with our Community Residential Care Programs, commonly known as board and care homes or foster care programs.

I think that each of these programs, in their own way, represent clear and very suitable noninstitutional long-term care services. I think that the Community Residential Care Program is of importance because we have had the authority to work with the board and care homes, but we have never had the authority to pay particularly for veterans in those homes.

And I think that policy represents a longstanding philosophy within the Veterans' Administration. We are interested in paying for medical and health benefits, but when we come to various programs at the social end of the spectrum, unless they are provided for in the Department of Veterans' Benefits series of benefits, we do not view the proper mission of our health-care system as extending to paying for the veteran to be in these particular modalities.

I think that the issue of extrapolation to the various home chore, homemaker, or other shopping services for the Department of Medicine and Surgery would be a departure from that traditional policy within the agency. Nonetheless, I think that it is important to point out that just because we have not had that authority does not mean to say that we have not been working with communities at large.

In fact, we have been establishing clearly more effective relationships with the Area Agencies on Aging and the State Units on Aging that sponsor these health-related programs under the Older Americans Act.

Now we are concerned about the extent to which those particular programs that come under the sponsorship of the Older Americans Act have been established and the degree to which they should be established in terms of meeting the aging needs of the population at large.

Nonetheless, we do have through the social work service and through various aspects of discharge planning and so forth an extensive network of relating to these Area Agencies on Aging and other community resources in the geographic area close to a facility, as it were, that provides for the health and social end of the spectrum.

Chairman **Murkowski**. Would you support including health-related services in the VA's mission of medical care and rehabilitation services?

Dr. **Mather**. I think that we have a responsibility on behalf of patients or clients, depending on how you look at them, to ensure that they get the full spectrum of services that they need. I think that it remains a matter of open debate the extent to which the VA itself should directly provide those health-related services, or rather refer VA patients or clients to those agencies in the community that provide them.

Chairman **Murkowski**. You have given us a very qualified answer, but soon you are going to have to make a decision about it. And the decision is going to have to be made on the basis of an analysis from the VA. They have the facts and figures. And the implication is that we have the obligation, which I think that we would all concur, to provide for the care.

But if the VA system is not capable or able to go ahead with the program to meet that crisis, then the other alternative has to come into play. So you are talking about policy. That has to be addressed one way or the other. We are going to change the policy or keep the policy the way that it is.

If the policy is going to be kept the way that it is, we have got to have more funding. And this issue has to be addressed. And I see a vacillation. You know, there is a pressure from the service organizations. And they have their point of view, and justifiably so. But in the meantime, 1990 is coming, and 5 to 8 years in planning is a long time.

Dr. **Mather**. Mr. Chairman, I do not think that you should interpret any of my remarks as being ambiguous. I think that I was very clear in pointing out that we in fact have a policy in which we seek to refer patients that need this end of the spectrum of care to those community sources that are available to us. And that is a continuous and ongoing matter.

Chairman **Murkowski**. Well, I think that you qualified your statement by saying that the decision has got to be made, or that the policy question has got to be addressed. And what I am urging is that we get to the point of addressing it and making a decision.

Do you basically agree that that is going to have to be done at some point in time?

Dr. MATHER. Mr. Chairman, I think that the VA's Aging Report and other reports that Dr. Gronvall referred to have directly addressed those particular items.

Chairman MURKOWSKI. Well, can you tell me then or answer the question that I addressed to Dr. Gronvall concerning just what are the requirements in numbers per year that we are going to have to meet outside of the medical area?

Dr. MATHER. Mr. Chairman, I suggest that that is an exceedingly broad question. There is no answer to it anywhere in the country at all.

Chairman MURKOWSKI. Someone has to address that question, Doctor. Otherwise, we are going to be out here guessing. And I think that it is a very basic question. In order to reflect on what the planning needs are going to be, somebody has got to do it. It might be challenged, but at least we have a basis to pursue the discussion.

Dr. MATHER. I think that we have a basis for answering you for the record as you requested. We can provide the kind of analysis that will give some trend information and some data that delineates precisely what we have been doing. As to the extent to which we should change policy in the future, we think that it is premature to extend the Department's authority in this area while we have a convenient and very appropriate way of referring those patients to the community at large at this point in time.

Chairman MURKOWSKI. Do you feel then with the current planning and implementation through the VA that we are going to be able to meet the challenge of the vast number of World War II veterans who are going to require help and nursing care within the timeframe of 1990 to the year 2000 without any change in the direction of policy?

Dr. MATHER. Mr. Chairman, I would primarily refer to Dr. Gronvall's response to that question. I would like to add my own point in this regard. It is that I think that we do have plans and that we have been preparing plans. The issue comes down to the extent to which appropriations will in fact fund those particular programs, which will really represent an extension of the capacity and the capability of the agency.

We are very concerned, particularly in my office, for the Adult Day Health Care Program, which you provided a legislated authority for, that we do certain specific studies on its cost effectiveness. We are concerned that we cannot do those until such time that these particular programs are expanded by additional funding.

Chairman MURKOWSKI. Thank you, Doctor. You may be excused from the panel if you wish.

Dr. MATHER. Thank you, sir.

Chairman MURKOWSKI. I appreciate you volunteering to come before the committee, and we appreciate your views.

[Responses of the Veterans' Administration to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; Hon. Arlen Specter, a U.S. Senator from the State of Pennsylvania; Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota; and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. You state in your written testimony that you are opposed to Section 2 of S. 876 which would establish a three year pilot program to allow elderly and catastrophically disabled veterans to live at home instead of in a nursing home. Under this program you would be provided the authority to contract for home-health services which hopefully would be less expensive than nursing homes. Without home-health personal care services, many people are forced to be institutionalized. Preventive medicine is considered good medical practice. How can you justify your position concerning home-health and personal care services in light of the increasing emphasis on preventive medicine?

Answer 1. We agree that home health and personal care services such as homemaker and chore services and services to assist individuals in such daily living activities as dressing and bathing can be valuable and beneficial for many individuals, particularly the elderly. However, as we stated in our prepared testimony and in answers to questions at the hearing, we oppose section 2 of S. 876 because the primary function of the Department of Medicine and Surgery, as established by law, is to provide medical services. Existing law bars VA from directly providing non-medical social and personal care services. Furthermore, VA provides many veterans with aid and attendance allowances authorized by 38 U.S.C. § 314(r)(1) which are then used by the veterans to obtain assistance with daily living activities. Finally, veterans, many with VA assistance, now obtain social and personal care services through community resources and it is our belief that this is appropriate.

We would note that the Department of Health and Human Services has addressed this exact issue of substituting health related and social services for nursing home care in the Long Term Care Channeling Demonstration Project. This was a large scale, multi-million dollar demonstration at ten sites for four years and was recently completed. The evaluation of the Channeling Project is underway and should be completed by December 1985. It is our view that there is little merit in duplicating this HHS effort, as Section 2 of S. 876 would do in many respects.

Question 2. In many communities home-health and personal care services are already available to those who would otherwise need nursing home care. However, in previous testimony you have maintained that your patient population is often sicker and poorer than the general population. If that is the case, how does the VA expect chronically ill veterans to be able to pay for home-health or personal care services?

Answer 2. We believe that there are two distinct patient populations addressed in this question. One population suffers from multiple chronic disabilities and may not be appropriately served by health related and social services as this population requires interventions by highly skilled professionals. While some of these individuals can be treated at home, it is unlikely that the cost of the services would be less than the per patient expenditure cap in Section 2 (g)(4) of S. 876. Accordingly, they could not be served by the pilot program proposed in that bill.

There is a second population whose quality of life would be greatly improved by the provision of health related and social services. Generally, the provision of these services would be most beneficial at a period of time prior to physical decline accompanying chronic illness. This second population does not appear to be "at risk" of institutionalization and could not be served by the pilot program which, for most veterans, would follow a hospital discharge, in accordance with Section 620 of Title 38.

The existence of health related and social services varies among communities. Eligibility for such services also varies. Certain home health services may be covered by Medicare, other services may be available as a regular Medicaid benefit or through a Medicaid waiver program. Other Federal programs, Title III and Title XX, for example, support nutritional centers. Many veterans are eligible for these services as citizens, and the VA does offer assistance in referring individuals to those community based activities.

Question 3. Section 2 of S. 876 was designed to cut costs by finding alternatives to institutionalization. The Congressional Budget Office agrees and has stated that there would be a savings of $1 million in 1986 and $2 million in 1987 and 1988. In your testimony you have voiced concern about the cost of this pilot program. How can you justify on the basis of additional cost, expanding the use of high-cost medical technology and experimental procedures, such as, heart transplants, while at the same time, denying chronically ill veterans the services they need to keep them at home on the basis of cost?

Answer 3. As we stated in our testimony of May 7, 1985, we have generally viewed the mandate of the Department of Medicine and Surgery as providing veterans with all needed medical services, either in VA operated facilities or in facilities for which the VA contracts. In acute care settings, certain diagnostic, surgical, and treatment interventions are expensive, but are necessary to provide quality care. We do not view the relationship between costs in two very different service settings as the deciding factor in planning for the long term care needs of veterans.

The provision of health related and social services is an "add-on" program and we do not envision any cost savings. The available evidence indicates that the population which would receive maximum benefit from these services is a population which is not currently served at VA expense. This population is also unlikely to use nursing home care services in the near future.

The VA has taken steps to broaden service delivery to chronically disabled patients. The number of Hospital Based Home Care Programs has increased by 63 percent in the past two years. Following the passage of P.L. 98-160, the VA has established five Adult Day Health Care Centers which will commence operation this summer. In the Community Residential Care Program, the VA has conducted extensive staff training programs which has led to the establishment of 15 new programs. The VA remains committed to expanding alternatives to institutional care in a manner which is consonant with our mission.

Question 4A. Could you be more specific when you say that this measure would damage the existing program and what suggestions could you offer to prevent such serious damage from occurring?

Answer 4A. There are currently approximately 12,000 veterans placed in VA approved Community Residential Care facilities (CRC). The great majority of these veterans suffer from chronic mental illness. In addition to room and board, the CRC provides them with supervision, personal care as needed, supportive emotional care, and therapeutic activities within a structured environment. Veterans pay for the cost of care in these facilities from their own income. The average cost of community residential care for veterans is approximately $450 per month. The VA provides outpatient services and "follow-up" visits in the home by social workers and other health care professionals to monitor the veterans' adjustment, and to provide guidance to the facility operator in the provision of care to the veterans. The average length of stay is in excess of two years.

The legislation, as written, would authorize the VA to pay for the same level of care which is now paid for by these 12,800 veterans themselves. The current program would, therefore, be damaged since those veterans now placed could rightfully demand that the VA begin to pay for their care as well.

Question 4B. If the VA had the resources to design its own program of non-institutional care for the chronically mentally ill, how would you design such a program?

Answer 4B. Effective treatment of veterans with chronic psychiatric disorders requires a full spectrum of interconnected inpatient, outpatient and community services. This network must have sufficient capacity and flexibility to allow patients, as they are ready, to move from one level of care to the next. Treatment components within this spectrum of care for chronically mentally ill patients include hospital care, domiciliary care, nursing home care, psychiatric transitional community-based residential treatment, community residential care, psychiatric hospital based home care and outpatient psychiatric treatment programs such as mental hygiene clinics, day treatment centers and day hospital programs. These components vary in terms of levels of care, intensity of therapeutic activity and cost. Many of these components are in place in the VA and provide the appropriate level of care for psychiatric patients. We, of course, are looking at various options as to how best to provide the other components.

Question 5. In your written testimony on Section 5 of S. 876, you stated, "Given the VA's record of performance in this area, we see no need for legislation such as section 5." You state further that the VA requires a comprehensive peer review-based program in every VA medical facility which is mandated by and governed by regulations. The draft of the recent General Accounting Office report shows however, that of the 13 medical centers that were reviewed, none of them fully complied with VA's quality assurance requirements under these regulations. GAO also found that of those centers that didn't comply, they did not believe their lack of compliance was a problem. What are your views of these findings and what efforts do you plan to undertake to address the lack of compliance?

Answer 5. We believe these findings demonstrate a common problem at VA and other non-VA medical centers - the failure to fully document formal mechanisms which exist and, in fact, achieve desired results. Often, on an informal basis, medical centers will be performing a number of activities which meet the intent of the HSRO regulations, VA policy and JCAH standards but are not formally recorded and credited.

The Department of Medicine and Surgery is reviewing medical center requirements set forth in the HSRO regulations to determine if our experience during the past two and one-half years since the regulations were published in final indicates a need to change, modify, delete, or add to these regulatory requirements. We have reason to believe that some of the requirements are no longer valid or appropriate.

In addition, the DM&S Office of Quality Assurance is developing a set of Criteria, Standards, Evaluative Algorithms and Measuring Instruments (SCEM) for use by the SERP assessment teams in their ongoing evaluation of the effectiveness of medical centers' HSRO programs. The Office of Quality Assurance is also drafting a revision to M-6, the DM&S policy manual for quality assurance, which will provide medical centers with additional information and guidance.

We would also like to point out that while the GAO draft report is critical of the Department's implementation of quality assurance programs at VA

Medical Centers the GAO makes no suggestion or implication that the quality of care at VA Medical Centers is substandard.

Question 6. At the Committee's June 6, 1984 hearing, the VA stated that there were approximately 900 cases of malpractice claims filed during the course of the year. At the time of the hearing the VA reported that there were no specific efforts to conduct trend analyses in quality of care problems or to have the Medical Inspector review information relating to malpractice claims. What efforts has the VA undertaken to conduct trend analyses in the quality of care area, including efforts to analyze malpractice claims statistics.

Answer 6. The Office of Quality Assurance conducts analyses of quality of care problems identified by the Department of Medicine and Surgery's Systematic External Review Program and the VA's Inspector General Office of Audit, along with deficiencies cited by the Joint Commission on Accreditation of Hospitals as the result of an on-site survey. The Office of Quality Assurance has a computerized management information system (ERMIS) to track and monitor SERP, IG, and JCAH external review findings and recommendations to medical center and the actions taken to correct them. ERMIS currently maintains a three year data base.

The Medical Inspector's Office in collaboration with the General Counsels' Office has established a data base tabulation of new claims and suits as well as settlements. Steps have been taken to receive timely clinical information on new cases, identifying practitioners involved. Physicians with malpractice settlements are being scrutinized for present competence by the Medical Inspector. In addition, the Office of Quality Assurance plans to conduct a study to determine appropriate uses of malpractice claim information in the Quality Assurance Program.

The Department of Medicine and Surgery's plans for a Medical District Initiated Peer Review Organization (MEDIPRO) program include a major new initiative to expand trend analyses of quality of care indicators, including malpractice claims. In addition, the Office of Quality Assurance will analyze problems identified by the Medical District MEDIPRO Boards or Regional Directors and will independently conduct pattern analysis of available quality of care data.

Question 7A. Since "patient injury control" is a function of VA's quality assurance program and is an integral part of risk management -- why have you not included the Medical Inspector's activities (i.e., patient injury control) as part of the new Office of Quality Assurance?

Answer 7A. The activities of the Medical Inspector's Office in the area of "patient injury control" are all retrospective which falls under the charge given that office. The program itself is a local effort geared to identifying and solving the deficiencias. The Medical Inspector collects all data for biannual statistical array and analysis with appropriate follow-up. The most crucial portion of patient injury control is that resulting in investigations which represent a great portion of the Medical Inspector's activities. These activities are not appropriate to the Quality Assurance office. The information generated by this program at each VA medical center is in their Quality Assurance Program. The Quality Assurance Program also has future plans to require analysis of portions of this database as part of our quality assurance efforts. We see no problem in these multiple uses of this data.

Question 7B. Since MEDIPRO is a district initiative, how will VACO assure itself that the districts are functioning as intended?

Answer 7B. The Office of Quality Assurance is responsible for monitoring and evaluating the effectiveness of the MEDIPRO program. As part of the MEDIPRO developmental planning process, an evaluation plan is being prepared to establish the ground rules and criteria for an assessment of how well the MEDIPRO program functions and the extent to which it meets overall objectives. The Systematic External Review Program (SERP) is one mechanism that may be used to provide oversight to MEDIPRO; independent data analysis will also be conducted by the Office of Quality Assurance to evaluate MEDIPRO effectiveness.

Question 7C. How do you plan to avoid duplication between MEDIPRO activities and SERPs?

Answer 7C. The PRO Program was designed to not duplicate HSRO, SIR or SERP. The PRO advisory committee has as one of its future agenda items the review of MEDIPRO and SERP to eliminate any duplication.

Question 7D. Resources to conduct SERPs have not been sufficient -- what is the outlook for resources to conduct both MEDIPRO and SERP activities?

Answer 7D. The Chief Medical Director believes peer review and monitoring activities to be critical in maintaining the highest quality of care to beneficiaries. The CMD expects to support the quality assurance program as his highest priority.

Question 7E. Within the new Office of Quality Assurance who will be responsible for analyzing and conducting trend analyses?

Answer 7E. We are in the process of analyzing the needs within the Office of Quality Assurance for a separate staff to conduct patient outcome data analyses for short range evaluation and long range planning. The Office of Quality Assurance is planning to hire additional staff with specific skills in data analysis and computer programming to supplement existing efforts in this area.

In the meanwhile, each of the four professional staffs within the Office of Quality Assurance is involved to some degree in conducting data analysis and trend analyses. For example, as part of the SERP pre-survey preparation, the team leaders evaluate hospital data from the Patient Treatment File, Automated Management Information System, and pre-survey information and develop a profile for SERP evaluators. The Health Services Review Organization staff review and analyze data on external review findings. The Patient Satisfaction Survey staff collect and analyze statistical data pertaining to VA medical center patients' satisfaction with the care they receive; trends are monitored over a three year period. The MEDIPRO staff will analyze quality of care outcomes, establish baseline data, and analyze trends.

Question 7F. In light of the personnel reorganization implemented in Central Office, do you still intend to initiate a risk management program, and if so, what are your specific plans in this area?

Answer 7F. The patient injury control program of DM&S is in essence a risk management program. We plan to review risk management activities, however, we have no specific plans at this point in time.

Question 8. On April 17, 1985 the Administration published a set of final regulations approving public access to statistics showing how well hospitals treat various illnesses. The information to be available to the public would include statistics on admission rates, lengths of stay, medical procedures used, the prevalence of hospital-acquired infections and death rates for different departments and illnesses. No information identifying the doctor or patient by name would be released to the public. What are your views on these regulations and in light of these regulations, how does the VA justify its position that all quality assurance information be confidential?

Answer 8. These regulations, published by the Department of Health and Human Services (DHHS), govern the acquisition, protection, and disclosure of information obtained or generated by Utilization and Quality Control Peer Review Organizations (PROs). Since the Veterans Administration is not subject to the provisions of Part B of Title XI of the Social Security Act or to HCFA PRO regulations, we did not publicly comment on the DHHS proposed rules. However, in general, we believe that the provisions in these PRO regulations concerning disclosure of confidential PRO information on practitioners, reviewers and institutions is consistent with similar provisions in the VA's HSRO confidentiality regulations (38 CFR Part 17).

The VA does not take the position that all quality assurance information is confidential. Rather, our position is and always has been that quality assurance information which identifies a health care provider or reviewer is confidential whether that individual is identified explicitly or implicitly. Thus, the VA's HSRO confidentiality regulations also permit the public disclosure of information or statistics on admission rates, lengths of stay, utilization of medical procedures, prevalence of hospital-acquired (or other) infections and death rates for different medical center departments and illness provided that the information or statistics does not identify a provider or reviewer.

Question 9. In your written statement on pages 2 and 3 regarding the VVRC program, you state that you oppose S. 875 because it would move the Vet Centers in the direction of a self-contained system. However, you also state that certain Vet Centers are unofficially providing the same services and resources which would be mandated by my legislation--job counseling, benefits counseling, and drug and alcohol abuse counseling. You do not oppose providing these services at Vet Centers as it is done unofficially, but you do oppose doing so on an official basis when the results could be measured. Could you please explain if there is an inconsistency in your testimony, and if not, why not?

Answer 9. Our testimony did not indicate that there are services being provided "unofficially" in Vet Centers. Our testimony indicated that many Vet Centers provide employment counseling in connection with readjustment counseling, as envisioned by the Congress and the Agency in the design of the program. This includes services provided by Department of Labor counselors out-stationed at Vet Centers when that is deemed desirable by local DVB Regional Offices and the Vet Centers. In rare instances, substance abuse counseling is provided when staff with qualifications in that area are available. In all these instances, services are provided only within the framework of readjustment counseling, that is, for veterans with problems in that area. All such services are carefully evaluated along with all other Vet Center services.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Question 1. What preliminary data is available regarding the success of the Vet Center Program? Please explain the evaluation process used?

Answer 1. Program success is evaluated on an ongoing basis as part of routine management. Data collection and analysis of all operations have revealed the following:

1. Utilization: Utilization of Vet Centers by veterans and family members increased from FY 1983 to FY 1984. In 1983, an average of 5,800 new clients were seen per month nationwide. In 1984, the number was 6,300. Similarly, the number for total veterans seen per month increased from approximately 17,000 average to approxidately 19,000 average.

2. General public response: As measured by numbers of volunteers forthcoming at Vet Centers, support from local veterans organizations, donations to general post funds earmarked for Vet Centers, and local media responses, public approval of the program's services is at a high level.

3. Complaints and inquiries: With over 375,000 persons seen by the program for services over a five-year period, only three inquiries conveying complaints re services have been received in VACO.

4. Productivity: Measures of cost per visit and visits per year direct service FTE indicate that cost per visit is relatively low and staff productivity is high.

5. International: Last year the program received an international tribute in that the Australian Ministry of Veterans Affairs established a system of Vet Centers modeled in all essential respects of the VA program.

Question 2. What has been, and currently are the supply and demand for readjustment counseling services?

Answer 2. Following the increase in numbers of clients seen from FY 1983 to FY 1984, most Vet Centers continue to experience a high demand for services. Because of persisting demand from sites without a Vet Center, the Congress has authorized an increase from 137 to 189 Vet Centers. The 52 new sites are currently being opened. With this major expansion in program size, it is our view that current resources are adequate.

Question 3. For the veterans who receive counseling, what are the rates of problems diagnosed and related to: post-traumatic stress disorder (PTSD), employment/training, alcohol/drug abuse, medical, other readjustment issues?

Answer 3. Our most recent tabulation of problems presented by Vet Center clients indicated the following percentages with the following key problems:

Marital	15.5
Anxiety/fear	34.7
Bad dreams/flashbacks	15.7
Vocational	41.7
VA questions	23.7
Alcohol/drugs	16.6
Interpersonal	31.9
Educational	10.2
Financial	11.7
Mental	14.1
Agent Orange	7.1
Suicide/homocide	5.7
Legal	6.7
Skill training	3.5
Discharge upgrade	2.4

(percentages add to more than 100 due to veterans presenting with problems in more than one category)

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Question 4. How has the VA responded to the above statistics?

Answer 4. a. Relatively higher statistics in the psychological category have been responded to by increasing the percentage of staff with professional mental health training.

b. Relatively higher percentage in the vocational area has been responded to by (1) hiring staff with employment counseling expertise, and (2) mobilizing Department of Labor counselors outstationed in Vet Centers.

c. Needs in areas where services are not usually provided by Vet Centers, e.g., substance abuse, are being handled by referrals to VA medical centers and clinics, and also by a very active program of networking with other community agencies to encourage them to take veterans for services.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. RUDY BOSCHWITZ, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Question 1. Does the VA currently have any specific process or mechanism for determining if local facilities are available to acquire?

Answer 1. The Veterans Administration does not currently have a specific process designed to determine if local facilities are available to acquire. The VA does comply with Executive Order 12372 which requires the notification of state governments when plans for major capital investments are under development. This notification and resulting coordination within the State does provide the opportunity to learn of available facilities.

Question 2. If so, where in the process do you review the local facilities? And what does this review entail?

Answer 2. When a programmatic need has been determined for a VA facility and VA learns of an existing facility which might obviate the need for construction, such facility is considered and if preliminary investigation confirms the buildings potential use, a site inspection is conducted. Although a rare occurence, the site inspection is designed to review the suitability and/or adaptability of the facility to meet the VA program requirements.

Question 3. Don't you think that once an area makes your list either to be replaced or built, that it is at that time the VA should be exploring local options?

Answer 3. We agree that when a facility is to be totally replaced or constructed as a new presence, VA should consider the availability of suitable local facilities which could be acquired.

Question 4. Can you tell me if the VA has any current plans to pursue existing facilities, either by lease or purchase? And if so, where are you in the process?

Answer 4. The VA currently has no plans to purchase or lease existing facilities for the purpose of serving as a VA medical center.

Question 5. What is the VA's position on S. 1007.

Answer 5. The VA is completing its analysis of S. 1007 and we plan to submit a report reflecting our views to the Committee as soon as possible.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. During the hearing, I asked a question about the statement on page 23 of the VA's testimony that disclosure of mortality and morbidity statistics "will, in fact, significantly influence the mortality and morbidity statistics reported in small, single-provider programs." Specifically, I asked if the VA meant to suggest that if such disclosure were potentially available the agency would be unable, through appropriate quality assurance activities, to ensure that morbidity and mortality data would be reported correctly and the witnesses' response was that there was indeed a concern. As a follow-up to that question, wouldn't that risk apply equally to two-provider and other relatively small services?

Answer 1. Yes, the risk would be the same for relatively small medical center services or programs with two providers as it would be in those with a single provider.

Question 2. In light of the response from Mr. Hendricks at the hearing that the VA has general authority to remove a health-care professional from contact with patients when determined necessary to protect patient safety, I do not understand why the VA raised the concern on page 27 of the agency's statement that providing access to a 4110 procedure in a case involving the proposed removal or restriction of clinical privileges "could delay the withdrawal of clinical privileges even if the health and safety of veteran patients were threatened." Please explain the basis for the concern.

Answer 2. Subjecting a reduction or revocation of clinical privileges to a section 4110 procedure would give rise at least to the implication that the lengthy section 4110 procedures must be fully exhausted before any action could be taken to remove a physician from patient care activity. Thus, the current established power to reassign or "detail" employees away from patient contact might well be held in any given case as involving a *de facto* suspension of privileges in breach of the legislation. Without agreeing that the proposed amendment would properly be so interpreted, this implication would create substantial risk that courts would read it that way.

Question 3. With further reference to the question of the possible delay related to a 4110 procedure, I believe you are familiar with the case involving a VA physician at a California VA medical center, which generated my interest in this case. It is my understanding of that case that the physician's clinical privileges were withdrawn through a local, peer-review process but that the physician still remains on the staff, drawing full salary, including full special pay bonus despite the fact that the physician is not performing any duties other than working in the medical library. I also understand that the facility management is now seeking to proceed against the physician under section 4110 so as to secure the physician's removal. Wouldn't it have been far more timely, if the facility management in the first instance, had proceeded under section 4110, and what would have been the problem with such an approach?

Answer 3. The premise is correct that management rapidly could have exercised its discretion to remove the physician from patient care duties and proceeded under section 4110. Discretion exists administratively to reassign employees during the pendency of disciplinary cases. While an employee is contesting disciplinary action under section 4110, he or she does remain on the rolls, drawing his or her salary.

Question 4A. On page 29, of your statement, you note your opposition to section 10 of S. 6 which, as you know, would require a joint report from the VA and the Departments of Defense and Health and Human Services on the issue of the Federal Government's responsibility to individuals who were in Vietnam with voluntary organizations.

Is the opposition stated only on the part of the VA or is that an overall Administration position?

Answer 4A. The opposition expressed in our testimony represents the VA position as well as the Administration position.

Question 4B. You mentioned title IV of Public Law 95-202 which established the DoD Civilian/Military Service Review Board as somehow being related to the proposed report. The employees of the voluntary organizations clearly were civilians and never were led to believe anything other than that. What in section 10 has suggested to the VA that the report is intended to relate to "veteran" status?

Answer 4B. The testimony stated that Title IV of P. L. 95-202 provided a means by which certain civilians who served in Vietnam might be able to obtain needed benefits and services by establishing veteran status for their service in Vietnam. Our intent was only to suggest one existing method by which civilians who served in Vietnam might be able to obtain needed benefits.

Question 4C. You mentioned the costs of the proposed report as a basis for your opposition. What do you estimate such a report would cost?

Answer 4C. We have no way at this time of providing a specific estimate of the cost of developing the required report. To develop a meaningful estimate would require extensive analysis and discussion among the three involved agencies, the DoD, VA and HHS, as to the scope, methodology and procedure for developing an appropriate report, to satisfy the requirements of the provision. Our testimony on this point was intended to convey the view that we do not believe the report is necessary, and expenditure of any funds to produce the report would not be prudent.

Chairman **Murkowski**. Dr. Sabshin, you may proceed.

TESTIMONY OF A PANEL CONSISTING OF: DR. MELVIN SABSHIN, MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION; AND DR. ORVILLE LIPS, PRESIDENT OF THE ASSOCIATION OF VA CHIEF PSYCHOLOGISTS, AND THE CHIEF OF PSYCHOLOGICAL SERVICES, VA MEDICAL CENTER, NORTH CHICAGO, IL

Dr. **Sabshin**. Thank you, Mr. Chairman. I am Melvin Sabshin, the medical director of the American Psychiatric Association. I am here this morning to express the APA's support in principle section 4 of S. 876. That is the community residential care pilot program for chronically mentally ill veterans. That is a lot of adjectives, but a very important program. I emphasize the word program for chronically mentally ill veterans.

The APA wants to commend you, Mr. Chairman, for introducing this bill, and for your statements on the floor in regard to it. I believe that what you have done is set in motion a process that shows compassion, and it is sensible and it is practical. I commend you and the committee for that.

You have a copy of my prepared statement and I would like to submit that for the record if I can, Mr. Chairman, and make some brief summary remarks.

Chairman **Murkowski**. It will be entered into the record.

Dr. **Sabshin**. Thank you, sir.

I speak here in the context of my role as chief executive officer at the American Psychiatric Association. I am also a former dean of a medical school, and chair of a dean's committee at the Westside VA hospital. And I was a member of the special medical advisory group for the medical director of the VA from 1978 to 1982. So I have some knowledge of the general issues.

But specifically, I would like to refer to section 4. I would like to place the issue of the community and residential care in the context of prior efforts in this country to deal with chronically mentally ill. Starting in the 1950's going through the 1960's, we in this country made some tragic mistakes. We made policy decisions that lacked adequate planning and adequate funding to carry them out.

Mr. Chairman, I am not speaking only about the VA here, but I am talking about our State mental health systems, our psychiatric care systems. We dumped patients into the community without providing appropriate services. And we today are seeing the aftermath of those tragedies.

The American Psychiatric Association has published a report on the homeless population. I know that you have seen part of this report and know about the reaction to it. For us to see that a significant number of the homeless population are veterans is shocking. It is tragic. And I know that many in this room are deeply hurt by that.

To see a newspaper in this city say that,

> The buddy of a homeless World War II hero dies. A man breaks his neck in a fall from a wheelchair five months after a friend froze at his feet

is a terrible, terrible thing for us to deal with. These were two people who were veterans, both chronic alcoholics, both homeless.

In talking about these problems, I am not faulting the VA per se, or placing specific blame. But I am saying that we have to learn from the prior errors that were made in order to develop a rational system for community care.

Mr. Chairman, in thinking about the proposals that you have made, I would hope that the report language would not stay silent on some specific matters. And I would like to make some comments about them.

First of all, in dealing with the chronically mentally ill, it is important to recognize that these are people who will need gradated differential service on leaving the institution. That means, in effect, that there must be degrees of supervision available for them. And I hope that your report language will take a look at that.

First, they will need a variety of housing settings. Second, it will be very important that these people have accessible psychiatric and rehabilitative services. In this context, I would point out that the VA's use of lithium has really been enormously successful for manic depressive patients. But as these people go into the community, the availability of medication, the availability of medical services and rehabilitative services is vital.

I am pleased that research in the field is developing new therapeutic techniques, advances in the neuro sciences and the psychosocial arena are really moving quickly. We need to have mechanisms in place to assure that the treatment is accessible.

I believe that the VA hospital based home care system is a positive one. I believe that there should be general medical services and good case management for our veterans. By case management, Mr. Chairman, I am talking about having people who are available as ombudsmen to be sure that these chronically ill veterans get appropriate rehabilitative and medical services.

I favor the pilot program that you propose. It will help us evaluate the effectiveness from both the clinical and cost effective standpoints.

Mr. Chairman, in your floor statement when you stated that we need followup services for chronically mentally ill to make a successful transition, you said it all.

But I want to add that your bill and the demonstration program it creates is a practical mechanism to accomplish this goal. May I say to you that when talking about eligibility for the program, I hope that you understand that the veterans need the capacity to reside at home in a substantially self-sufficient manner, and that this aspect needs a bit more attention.

These are people who often are without families and other supports. In all likelihood what we mean by "at home" for many of these people is that it is going to be a group home. They do not have families as you and I, and most of us here do. They are people without these kinds of social supports.

And when we say in a "substantially self-sufficient" manner, I hope that it is understood that we mean something that includes minimal supervision. That will be a worthy goal.

I am convinced that further research and advances in the neuro sciences will help us accomplish this purpose.

Mr. Chairman, I would like to conclude my remarks at this point, and say that I feel privileged to be here. I laud your efforts to develop a practical program, a good pilot program. I urge and ask that at the end of this pilot program that you ensure that these veterans are not forgotten at that time. Thank you, sir.

Chairman **Murkowski**. Thank you, Dr. Sabshin.

[The prepared statement of Dr. Melvin Sabshin, medical director, American Psychiatric Association, follows:]

PREPARED STATEMENT OF DR. MELVIN SABSHIN, MEDICAL DIRECTOR OF THE AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, DC

Mr. Chairman, Members of the Committee:

I am Melvin Sabshin, M.D., Medical Director of the American Psychiatric Association, a medical specialty society representing over 30,000 psychiatrists nationwide. The APA appreciates the opportunity to testify before the Senate Committee on Veterans Affairs to provide our views on the Community Residential Care provisions of the Veterans Administration Health Care Programs Improvement Act of 1985 (S. 876).

We would like to begin our testimony today by commending you, Mr. Chairman, for introducing legislation which addresses the particular needs of chronically mentally ill veterans. We are grateful to you for recognizing the importance of providing adequate community residential care for those veterans for whom acute long-term care is no longer appropriate or necessary.

Our comments about this legislation are made not as experts on the Veterans Administration's Health Care System per se, but rather as psychiatrists concerned with the treatment of all chronically mentally ill patients. We believe that these individuals, whether veterans or non-veterans, should be treated in the least restrictive setting, which we believe -- and believe you would agree -- means optimum therapeutic setting and thus assures that psychiatric patients receive meaningful and appropriate treatment, whether in inpatient or in community-based facilities and programs. We have long advocated the need for a comprehensive community support system to meet the needs and develop the potential of our nation's large population of chronically mentally ill.

Our society has, unfortunately, made many tragic mistakes in trying to achieve this goal over the past few years. The era of deinstitutionalization in the 1950's and 1960's was ushered in with much naivete and many simplistic notions as to what would become of the chronically and severely mentally ill in new community settings. The importance of psychoactive medication and a stable source of support was perceived but the importance of developing such fundamental resources as supportive living arrangements was often not clearly seen, or at least not implemented. As a result, the dilemma of what to do with the chronically mentally ill is even more acute today, and can be perhaps most obviously evidenced by the growing numbers of homeless mentally ill on our streets. Regrettably, our nation's veterans are no exception to this problem. In fact, I understand it has been estimated that up to 50 percent of New York City's homeless population may be veterans.

The APA has recently reaffirmed its strong belief in the advantages of community residential care in the treatment of the chronically mentally ill in its Task Force Report on the Homeless Mentally Ill, which was completed just last year. We found that many chronically mentally ill persons for whom institutionalization is not appropriate would be able to make a successful transition into the community provided that certain alternative services are provided or made available to them. I would like to briefly outline some of these general requirements, before I specifically discuss how they might apply to your legislative proposal's community residential pilot program for veterans.

First, an adequate number and ample range of graded, stepwise, community housing settings must be established. Most housing settings that require people to manage by themselves are beyond the capabilities of the chronically mentally ill. There should be settings offering different levels of supervision, both more and less intensive, including board and care homes, satellite housing, and foster or family care. Organized living arrangements can help stabilize the lives of such individuals to a marked extent.

Second, adequate, comprehensive, and accessible psychiatric and rehabilitative services should be available and must be assertively provided through pro-active outreach services when necessary. There must be an adequate number of direct psychiatric services that provide (a) outreach contact with the mentally ill in the community, (b) psychiatric assessment and evaluation, (c) crisis intervention, including hospitalization, (d) individualized treatment plans, (e) psychotropic medication and other somatic therapies, and (f) psychosocial treatment. Also, there should be an adequate number of rehabilitative services providing socialization experiences, training in the skills of everyday living, and social rehabilitation. Both treatment and rehabilitative services must be provided assertively -- for instance, by going out to patients' living settings if they do not or cannot come to a centralized program. (This is not dissimilar to some of the homemaker-chore and other home-based health and rehabilitative services provided under programs for the aged, though it is absolutely critical not to underestimate the difficulty of working with many of these patients.) I understand that the Veterans Administration already has in place a program called the Hospital Based Home Care system that does not now cover psychiatric services, but that might be easily and cost-effectively adapted for use with the chronically mentally ill.

Third, general medical assessment and care must be available. Since we know that the chronically mentally ill have three times the morbidity and mortality of their counterparts of the same age in the general population, the ready availability of general medical care is essential and critical. Again, this could occur within the housing sites, or within the outpatient rehabilitation programs.

Fourth, a system of responsibility for the chronically mentally ill living in the community must be established, with the goal of ensuring that ultimately each patient has one person responsible for his or her care. Clearly, the shift of psychiatric care from institutional to community settings does not nor should not in any way eliminate the need to continue the provision of comprehensive services to the mentally ill. Indeed, the need for asylum for such persons may be even greater when confronted by the larger community setting. Even the mentally well have difficulty dealing with a number of bureaucracies, both governmental and private, and with getting their needs met. Patients can easily get lost in the community as compared to a hospital where one may be concerned that they may have been neglected, but at least their whereabouts were known. It is these problems that have led to the recognition of the importance of case management. It is probable that many of the homeless mentally ill would not be on the streets if they were on the caseload of a professional or paraprofessional trained to deal with the problems of the chronically mentally ill, monitor them, and facilitate their receiving services. We must ensure that those now in facilities or in need of community-based care do not become the homeless for lack of managed, available care and treatment.

In summary, the survival of long-term patients, let alone their rehabilitation, begins with an appropriately supportive and structured living arrangement. Other treatment and rehabilitation are of little avail until patients feel secure and are stabilized in their living situation. Deinstitutionalization means granting asylum in the community to a marginal population, many of whom can cope only to a limited extent with the ordinary demands of life, and have strong dependency needs. We have learned that dependency must be fully accepted when dealing with the chronically mentally ill, and that this acceptance needs to be of the total extent of patients' dependency needs, not simply of the extent society wishes to gratify these needs. We have learned, or should have learned, to abandon our unrealistic expectations and redefine our notions of what constitutes success with these patients. Sometimes it is returning them to the mainstream of life; sometimes it is raising their level of functioning just a little so they can work in a sheltered workshop. But often times success is simply engaging patients, stabilizing their living situations and helping them lead more satisfying, more dignified and less oppressive lives.

Having shared with the committee our views on the general needs of the chronically mentally ill in the community, we would like to provide for the committee's consideration some specific comments about the pilot program proposed in S. 876.

We understand legislation passed in the 98th Congress (Public Law 98-160) provides the Veterans Administration with authority to place veterans in community settings under certain circumstances, but does not provide for the paymen of this care. Furthermore, we understand supervision is very minimal for the few veterans who can afford to participate in the program. Certainly Section 4 of your legislation would seek to respond to this situation by providing the VA with the authority to conduct a pilot program to contract for community residential care for certain chronically mentally ill veterans. We would suggest that there be committee report views to clarify that the purpose of this pilot program is to not only provide community residential settings for some of these veterans, but to also pay for them, on a limited basis.

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According to the VA's own data, approximately 10 percent of the chronically mentally ill veteran population currently in long-term care facilities could make a successful transition into the community, but are not currently referred because of their inability to pay. By providing the VA with an additional authority on a pilot program basis, the VA would be able to treat these veterans more appropriately, and perhaps even more cost-effectively. In addition, the VA would be able to take a leadership role by using its integrated and comprehensive health care system to promote a successful community based program for the chronically mentally ill — a system of care that we could then look to as a model national program.

We are particularly encouraged to see included in the bill provisions for case management, the importance of which was discussed earlier in my testimony. Case management is defined in the legislation as "the coordination of all services furnished, but not limited to, outreach, screening, assessment of needs, planning, referral, provision for or arrangement of services, monitoring, reassessment, and follow-up." All of these are important in ensuring the success of community care for the chronically mentally ill, and we again commend you, Mr. Chairman, for recognizing the critical need for such services. We do however, have several concerns about the types of housing and medical services that will be provided as part of this pilot program and would like to share specific recommendations which we believe could strengthen and improve the legislation.

Our first concern refers to the establishment of proper community settings. Current law states that "a community residential care facility means a facility that provides room and board and such limited personal care for and supervision of residents as the Administrator determines, in accordance with regulations prescribed." Since it is our understanding that such regulations have never been formally prescribed or approved, it is very unclear what kind of care or supervision would be considered appropriate for these veterans. As I said earlier, most housing settings that require people to manage by themselves are beyond the capabilities of the chronically mentally ill. We believe it most important that the legislation articulate these requirements, and thus ensure that the settings are not only physically safe for the

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patients, but also that the supervision provided is based on the needs of the individual patient.

Second, although the need for case management is addressed in the legislation, we feel that the need for adequate, comprehensive and accessible psychiatric and medical services is not adequately addressed. In introducing this bill, Mr. Chairman, you acknowledged in your floor statement the need for these follow-up services "in order for the chronically mentally ill to make a successful transition into the community". We are pleased that you recognize the importance of these services, and we would suggest that the psychiatric and other medical follow-up services be specifically addressed in the legislation.

Finally, we know you share our concern that you and the legislation reported by the Committee will somehow ensure that the patients who participate in this pilot program and are successfully placed in the community -- using realistic expectations and better defined concepts of what constitutes success with patients -- will continue to be adequately and appropriately cared for by the Veterans Administration after the pilot program expires on December 31, 1988.

Mr. Chairman, we support this legislation in principle, and applaud you for your initiative in responding to the needs of this often forgotten population of veterans. Our concerns we believe are shared by you, the Committee and the Congress to make certain that the legislation is implemented in the best interests of the patients involved. We are privileged to have had the opportunity to submit our views and recommendations regarding your proposed pilot program. We look forward to working with you not only to ensure that it is designed to best meet the needs of the chronically mentally ill veteran, but also to ensure its passage. We firmly believe that this program, properly implemented, could serve as a model not only for the Veterans Administration, but also for community residential programs across the country.

Chairman **Murkowski**. One of the difficulties in appropriately targeting the program of community residential care for the chronically mentally ill is in assessing those patients who would be most appropriate for such care and would have the greatest chance for success in the transition into an environment such as you've described.

I'm wondering what your suggestions might be on other methods that could be offered to the VA to determine how we target that population?

Dr. **Sabshin**. Let me answer a few things now, Senator, and then submit for the record, if I might, some additional statement.

The problem, as I've seen it, is that people go into the community facilities—and in the absence of any kind of supervision, they leave these facilities and become part of the population that drifts and becomes homeless.

To make treatment available to them in these circumstances will help a substantial number of these people to move up, in a gradated capacity, to function better.

You recall my comment, not to expect miracles, not to expect that many of these people will move into work situations. But substantial improvement will mean capacity to live a decent life in a group home and, hopefully, in some cases at least, to go beyond this.

The other alternative for us—and them—is continued hospitalization. And I don't think we want to go back to that system. I think we have made advances in moving people out of institutions, but we expected too much out of that. Of course, some people will need longer-range hospitalization.

Chairman **Murkowski**. Let me ask you this, Doctor.

Is it your interpretation that where you and the VA depart on this issue is that the VA contends that they need the specialized care that only be made available in a VA facility or a hospital or a psychiatric ward?

Dr. **Sabshin**. I don't believe they contend that, sir.

You may get a different opinion if——

Chairman **Murkowski**. OK.

Dr. **Sabshin**. I think they'd be in substantial agreement that community placement and residential approach would be useful.

I think their answer might be they're providing some of these services already in outpatient settings and in an attempted outreach. And yes, they are doing some of these things. But the current authorization does not provide payment for these services; and the absence of payment serves as a major disincentive for veterans to have this kind of care.

Chairman **Murkowski**. Well, obviously, the private sector isn't going to take on this capability without reimbursement.

Dr. **Sabshin**. Well, I think there are new opportunities for the private sector to be involved, Senator. I would not say this so lightly; I don't believe you mean that. I think you meant that as a challenge to me.

Chairman **Murkowski**. Yes.

Dr. **Sabshin**. I believe the opportunity for the private sector to be involved—for negotiations with SSDI, and with other systems, is worth looking into—so that I would be in favor of bringing in the private sector. As a matter of fact, I am an advocate of private sector involvement with our State chronically ill mental population. There are also some examples of new partnerships between private sector universities and Government facilities. I would explore these avenues.

Chairman MURKOWSKI. But you say there would have to be a change in the authorization, which allows for reimbursement.

Dr. SABSHIN. Yes, there would, of course.

Chairman MURKOWSKI. I am confused when you say it is working now and——

Dr. SABSHIN. Excuse me, sir. I meant that it's working in some State mental health systems, that contracts have been arranged with certain private sector organizations that——

Chairman MURKOWSKI. By the VA?

Dr. SABSHIN. No, not by the VA—not that I know.

Chairman MURKOWSKI. OK.

So, it's working in other areas outside the VA. And so your recommendation is specific, that there be an authorization for reimbursement to these residential care facilities in areas. And wouldn't there be a reasonable risk that these so-called "home care facilities" wouldn't be able to provide the quality of treatment or we would somehow be having inadequately trained people providing some of this care?

How do you police to make sure that overcharging doesn't occur because the remuneration is going to some private sector health-care facility which doesn't have the capabilities to do much more than offer babysitting, instead of providing rehabilitative services?

Dr. SABSHIN. Yes, sir. I don't believe I can answer that question fully. But in my comments, I talked about the need for accessible rehabilitative and medical facilities, including the psychiatric facilities.

Chairman MURKOWSKI. Yes.

Dr. SABSHIN. And the VA already has certain of these programs in place. Your question would pertain to places that may be quite distant from VA facilities or the practicalities of those situations. And that's one area, certainly, where some private involvement should be available.

How to prevent rip-offs there, I would submit to your judgment better than to mine. I would hope, of course, as we do, that the medical profession would police itself and that the other groups would police themselves. But I think some other provisions would have to be made.

Chairman MURKOWSKI. Dr. Lips.

Dr. LIPS. I'm Orville Lips, president of the Association of VA Chief Psychologists and the chief of psychological services at the VA Medical Center in North Chicago, IL.

On behalf of the Association of VA Chief Psychologists and the American Psychological Association, I am pleased to have this opportunity to comment on the process of implementation of grade reductions within the VA's health-care system.

We support Senate bill 6 introduced by Senator Cranston, which would provide oversight to VA grade reduction plans.

In the interest of time, I ask that my entire written statement be entered in the hearing record and I will only summarize major point.

Chairman **Murkowski**. Your statement will be entered in the record of this hearing.

Dr. **Lips**. Thank you, Mr. Chairman.

I must state from the beginning that the Association of VA Chief Psychologists and the American Psychological Association oppose the staff and grade reduction proposal and its current implementation. We oppose this grade reduction proposal on three grounds.

Mr. Chairman, first, the VA had no plan to implement this proposal and ensure appropriate reductions of mid-level management positions as recommended by the Grace Commission.

The agency has, at this time, imposed a total freeze on all grade 11 through 15 positions, subject to regional director approval. While this may ensure that the total reductions imposed by the Office of Management and Budget will be met, it will create havoc in our medical centers and has the potential to destroy critical health-care programs for our veterans.

For example, this week I'm in the process of attending the first major VA conference on post-traumatic-stress disorders since the Congress last year provided special funding for inpatient treatment programs for our Vietnam veterans.

These programs, in attempting to be implemented and come up to speed, have been seriously hampered by the total freeze that has been imposed on key health-care positions within the grade 11 through 15 range. Without relief, these programs will, at best, be delayed in their implementation and, at worst, be staffed by less than adequately qualified staff.

Second, the grade bulge in the number of 11 through 15 positions used by the Grace Commission to justify grade reductions does not exist within the VA's Department of Medicine and Surgery. Grades 11 through 15 comprise less than 15 percent of the total Department of Medicine and Surgery work force. This is compared to the more than 33 percent found in other VA departments and the 38 percent present Governmentwide.

Third, the staff and grade reductions will be detrimental to the VA health-care system and to our veterans. The vast majority of the Department of Medicine and Surgery staff in grades 11 through 15 are professional health-care providers.

We note that the VA has requested and received an exemption from these reductions for health-care providers currently employed under title 38, primarily physicians and nurses. This exemption, while supportable, provides a very narrow view and a lack of understanding of the complexity of the health-care needs and services provided to our veterans.

There are many VA health-care providers employed under title 5, including psychologists, social workers, pharmacists, chaplains and others who were not exempted from the staff and grade reduction program.

The policy of reducing the staff and grade levels of health-care providers employed under title 5, while exempting other health-care providers under title 38, can only work to the detriment of quality health care within the Veterans' Administration.

We believe that nonexempted providers will seek employment outside the VA system, rather than accept grade reductions or poor working conditions due to staff reductions.

We also believe that the VA will experience difficulty recruiting and hiring high-quality professionals to work in the VA.

For instance, in my own service, we now face the possibility of hiring temporary or part-time psychologists as the only way to fill key health-care programs. That does not build a strong and positive work force in the VA.

Let me now focus on my own profession of psychology as an example of the impact that the staff and grade reductions will have on the quality of VA health care.

Shortly after World War II, the large number of psychological casualties of large-scale modern warfare, those that we now recognize as post-traumatic-stress disorders, prompted the VA to integrate mental health care with physical health care.

In 1946, the American Psychological Association helped the VA to create their Psychology Training Program, an extensive system of faculty, graduate students, and pre-doctoral internship support.

Today, this nearly four-decade commitment to increasing the psychological services available to veterans has succeeded.

The qualification standards for psychologists working in the VA are the highest of any Government agency.

The VA continues to provide a significant portion of the internship training for new psychologists in our country and is currently the largest single employer of doctorally trained psychologists in the country.

This dedication to providing quality psychological services to veterans has been a hallmark of the VA. Psychologists serve our veterans and the Veterans' Administration in several capacities: as direct service practitioners, as consultants, as researchers, and as administrators.

In addition, psychologists have led the VA in the development of some of the greatest innovations in health care. These include the creation and operation of mental hygiene clinics, day hospitals and day treatment programs, satellite clinics, drug treatment units, alcohol treatment programs and, most recently, the treatment of post-traumatic-stress disorders for our Vietnam veterans.

In my written statement, I have listed many major programs which have been pioneered by VA psychologists and have since gained national prominance for the VA throughout our Nation's health-care system.

Suffice it here to say that the partnership between psychology and the VA has been productive for psychology, for our veterans and for our Nation. And this is what the OMB and OPM plan is proposing to dismantle.

The question that remains is who is going to provide mental health care to our veterans when the psychology programs and other programs are dismantled due to grade reductions? I doubt that it will be bachelor-trained mental health technicians.

To proceed with the recommended grade reductions in psychology will mean the curtailment of a relationship and of a series of programs that have been 40 years in the making, which would be a monumental loss and betrayal of our veterans and our Nation, and comes at a time when the VA anticipates an even greater demand for services from Vietnam veterans, as has been noted previously today and from the increasing number of veterans aged 65 and over.

Mr. Chairman, the effects of the administration's efforts to reduce the health-care programs of the VA through staff reductions and grade de-escalations have already taken their toll on psychologists. From January 1, 1984 to January 1, 1985, the Department of Medicine and Surgery lost approximately 100 psychology positions. This was the result of both the DRG process and the grade reduction program.

The percentage of reduction is much greater than the 2-percent specified by OMB and will be much greater by the end of the year under the continuing freeze.

It is our hope that this committee will work wholeheartedly to exempt the VA totally from further staff and grade reductions. Short of this, we feel that all VA direct health-care service personnel in title 5, as well as those in title 38, should be exempted from further staff and grade level reductions.

We strongly support the provision in Senate bill 6 to give a considered and rational review to any grade reduction plans.

I thank the committee and you, Mr. Chairman, for your continued interest and efforts on behalf of our veterans and for allowing me this opportunity to present our views.

I would be happy to answer any questions you may have.

Chairman MURKOWSKI. Thank you, Doctor.

[The prepared statement of Dr. Orville Lips, president of the Association of VA Chief Psychologists, and the Chief of Psychological Services, VA Medical Center, North Chicago, IL, follows:]

PREPARED STATEMENT OF DR. ORVILLE LIPS, PRESIDENT OF THE ASSOCIATION OF VA CHIEF PSYCHOLOGISTS, AND THE CHIEF OF PSYCHOLOGICAL SERVICES, VA MEDICAL CENTER, NORTH CHICAGO, IL

Mr. Chairman, and members of the Committee, I am Dr. Orville Lips, President of the Association of VA Chief Psychologists, and the Chief of Psychological Services, VA Medical Center, North Chicago, Illinois. On behalf of the Association of VA Chief Psychologists and the American Psychological Association, I am pleased to have this opportunity to comment on the process of implementation of grade reductions within the Veterans Administration and the damage these reductions will have on the quality of health care programs within the VA health care system. We support the provisions of S. 6, the bill introduced by Senator Cranston, which would provide oversight to VA grade reduction plans.

The Association of VA Chief Psychologists is the member organization for the 154 chief psychologists within the VA system. Chief psychologists are the administrative department heads, who develop treatment, training, and research programs, and supervise the work of the over 1,200 staff psychologists within the VA Department of Medicine and Surgery.

The American Psychological Association, representing over 76,000 members, is the primary national psychology organization. The Association is active in promoting responsive concern by the profession on a variety of social and public policy issues; disseminating psychological knowledge to enhance and increase human progress and well-being; developing standards of education, ethical conduct, and professional practice; and promoting research by working to improve research methods and conditions. The APA has a long and proven record of working with the VA to provide exemplary service to our nation's veterans.

Our primary concern in coming before this Committee today is to present to you our position regarding the Administration proposal, delivered through the Office of Management and Budget and Office of Personnel Management, to reduce VA personnel through staff and grade level reductions. I must state from the beginning that the Association of VA Chief Psychologists and the American Psychological Association oppose the staff and grade reduction proposal and its current implementation.

These proposals grew out of the President's Private Sector Survey on Cost Control, known as the Grace Commission, which estimated that there was a "grade bulge" in the number of GS/GM 11-15 positions in the Federal workforce relative to the private sector, and recommended a number of changes regarding the VA's management of its benefits and health care programs. To implement the Commission recommendations on "Improved Position Management," the VA issued Circular 10-84-199 (November 20, 1984) which presented the Administration position (complete circular is attached):

> "The Office of Management and Budget (OMB) and Office of Personnel Management (OPM) have developed a program which will decrease the number of GS/GM 11-15 positions in the government by 2% in FY 85. Positions abolished at the GS/GM 11-15 level may be restructured and established at grades 1-10. To effect these reductions, OMB has withdrawn funds for these reductions from the Aging budget in Fiscal Year 1985.
>
> Title 38 . . . positions [physicians, nurses, optometrists, podiatrists, dentists] are excluded from program controls."

We oppose the Administration's proposal for staff and grade reductions on two grounds. First, that the "grade bulge" in the number of GS/GM 11-15 positions used to justify the reductions does not exist within the VA Department of Medicine and Surgery. GS 11-15's comprise only 14.7% of the total Department of Medicine and Surgery (DM&S) workforce (approximately 15,000 of 104,000) as compared to 33.4% in other VA Departments (approximately 6,200 of 18,500).

Second, the staff and grade reductions will be detrimental to the VA health care system and, thus, to our veterans. The vast majority of the DM&S staff in grades 11-15 are professional direct service health care practitioners. The exemption of the health care practitioners under Title 38, while supportable, provides a very narrow view and a lack of understanding of the complexity of the health care needs and services provided to our veterans. There are numerous VA health care practitioners, including psychologists, under Title 5 who were not exempted from the staff and grade reductions. The policy of reducing the staff and grade levels of health care practitioners under Title 5, and exempting other health care practitioners under Title 38, can only work to the detriment of quality health care within the Veterans Administration.

This will happen in two ways. One will be that non-exempted health care practitioners will seek employment outside the the VA health care system rather than accept grade reductions or poor working conditions due to staff reductions, and thus the VA will loose experienced and well-qualified personnel. The second is that the VA will experience difficulty recruiting and hiring high quality professionals to work in the VA health care system. In addition, this will likely result in a high turnover rate of practitioners within the VA, where only the new-to-the-field personnel will accept employment, and the more experienced will leave to assume appropriate level positions in the private sector.

How will this hurt the VA? It is difficult to imagine how the VA will be able to maintain the current range of quality care programs without well-trained and experienced health care staff to provide the program planning and development, supervision, and service delivery that have become the standard for comparison in such areas as rehabilitation, ambulatory and self-care, the management of chronic patients, post-stroke care, Post-Traumatic Stress Disorder (PTSD) counseling, and alcohol and drug treatment programs.

How will this hurt veterans? As these quality care programs are diminished due to the lack of high quality health care personnel, it is the veterans who will suffer most. The American Legion has stated that the most frequent users of the VA health care system are "the oldest, the poorest, and the sickest of our nations' veteran population." They are the veterans who are least likely to be covered by private health insurance plans and who, at best, will be inadequately covered under Medicare and Medicaid. In short, the VA often provides services to those who have no where else to go for comprehensive health care. As a nation we can do no less than stand by our veterans in their time of need.

I have thus far spoken generally. Let me now focus on my own profession of psychology as an example of the detrimental impact that the staff and grade reductions will have on the quality of VA health care. Shortly after W.W.II, the VA recognized that traditional medical approaches were inadequate to meet the needs of large numbers of casualties, many of whom were psychological casualties of large-scale modern warfare, suffering from what we now recognize as PTSD and other combat-related disorders. At that time, the leadership of DM&S developed a policy of, and made a commitment to, a comprehensive, holistic health care delivery system, and particularly to the integration of mental health care with physical health care. To implement this approach, DM&S contracted with the American Psychological Association in 1946 to create the VA Psychology Training Program--an extensive system of faculty, graduate students and predoctoral internship support for veterans in the field of psychology, and for non-veterans who wished to train within the VA system.

This nearly four decade commitment to increasing the psychological services available to veterans has succeeded. The VA currently is the largest single employer of doctorally trained psychologists in the country. The qualification standards for psychologists working in the VA DM&S are the highest of any government agency, including the Department of Defense, requiring a doctoral degree from an APA accredited graduate program and an APA accredited, full time internship. This dedication to providing quality psychological services to veterans has been a hallmark of the VA and, in our judgment, of great benefit to this nation's veterans. It is fair to say that the VA was the birthplace of modern clinical and counseling psychology, and continues to provide a significant proportion of the internship training for new psychologists. Today more than 1,400 doctoral-level psychologists work full-time in the VA DM&S, 66 percent of them are VA-trained.

Psychologists serve our veterans and the Veterans Administration in several capacities. As direct service practitioners, psychologists conduct assessments and evaluations of patients, provide psychotherapy (e.g., individual, group, marital and family), therapeutic programming, and referral of patients to specialized psychological services (e.g., biofeedback, hypnotherapy, neuropsychology, vocational rehabilitation). As consultants, psychologists provide educational and clinical consultation services to other health care professionals, related to such areas as dental pain and anxiety and with somatic problems. As researchers, psychologists are working in such areas as preventive medicine and patient compliance with treatment. And as administrators, psychologists have responsibility for program coordination with halfway houses, multi-disciplinary therapy programs and alcohol dependence treatment programs. In addition, DM&S psychologists have led the VA in the development of some of the greatest innovations in health care. These include the creation and operation of mental hygiene clinics, day hospitals and day treatment programs, satellite clinics, drug treatment units and alchohol treatment programs, and the treatment of Post-Traumatic Stress Disorders.

The major clinical programs which have been pioneered, researched and evaluated by psychologists in DM&S, and which have since gained national recognition for the VA throughout the non-VA health care community include:

- o Operant conditioning programs for both acute and chronic patient populations
- o Programs emphasizing self-responsibility for disabled and long-term psychotic patients
- o Biofeedback and relaxation methods for the treatment of severe tension, anxiety and chronic pain
- o The neuropsychological diagnosis and treatment of various brain dysfunctions
- o Crisis intervention and rehabilitation management with spinal cord injury problems
- o Marital and family therapy systems
- o Optimal methods for crisis intervention and significant research in suicide and homocide
- o Special treatment programs for staff who deal with death and dying
- o The effective application of behavior modification in treating chronic cardiovascular problems and the treatment of the psychological connection of renal dialysis
- o Major contributions to cooperative studies on the effective treatment of schizophrenia
- o Extensive research on the efficacy of psychotherapy
- o The development of innovative approaches in psychotherapy, including intensive short-term approaches
- o The research and development of treatment metnods for sleep disorders
- o A host of treatment approaches to the specific problems of veteran subpopulations, including the readjustment counseling of Vietnam veterans

The partnership between psychology and the VA has been productive, for psychology, for the veterans, and for the nation.

The science and profession of psychology is the most advanced discipline devoted to understanding, explaining, predicting and modifying human behavior. And this is what OMB and OPM are proposing to dismantle and discard. With their program to reduce the number of psychologists in the VA and reduce the GS/GM 11-15 grade levels of psychologists in title 5, and, thus, turn these programs over to B.A. level technicians, the Administration has given a clear signal that it does not believe that the veterans of this country deserve the highest quality health care and treatment.

The need for psychological services is even more pressing in the VA than in the general population. Research has shown that the largest percentage of casualities during armed conflict -- approximately 30 percent -- are psychological and emotional. And, as we have learned from the experience of our Vietnam veterans, the effects of PTSD can surface many years after the precipitating experiences.

Who is going to provide mental health care to our veterans when the psychology programs are dismantled? B.A. level mental health technicians? I think not. To proceed with the recommended grade reductions in psychology will mean the curtailment of a relationship and of a series of programs that have been forty years in the making. This would be a monumental loss and betrayal of our veterans and our nation, and comes at a time when the VA anticipates an even greater demand for services from Vietnam veterans and from the increasing number of veterans age 65 and over.

Mr. Chairman, the effects of the Administration's efforts to reduce the health care programs of the VA, through staff reductions and grade de-escalations, have already taken their toll on the psychologist providers in our medical centers and outpatient clinics. From January 1, 1984, to January 1, 1985, DM&S lost 100 psychologist staff positions. This is a result of both the DRG resource allocation process and the grade de-escalation program. The percentage of reduction is much greater than the 2 percent specified by OMB, and will be much greater by the end of this year.

It is our hope that this Committee will work whole-heartedly to exempt the VA from further staff and grade reductions. Short of this, we feel that all direct health care service personnel in Title 5, as well as those in Title 38, should be exempted from further GS/GM 11-15 staff and grade level reductions. We support the provision in S.6 to give a considered and rational review to any VA grade reduction plans.

The Association of VA Chief Psychologists and the American Psychological Association thank the Committee for their continued interest and efforts on behalf of our veterans, and for allowing me the opportunity to present our views. Thank you.

Veterans Administration
Department of Medicine & Surgery
Washington, D.C. 20420

CIRCULAR 10-84-199
November 20, 1984

TO: Regional Directors; Directors, All DM&S Field Activities

SUBJ: Improved Position Management: GS/GM 11-15 Positions

1. Purpose. The purpose of this circular is to supplement the provisions of VA Circular 00-84-33, dated September 13, 1984, by outlining Departmental guidelines and requirements in implementing the reduction of GS/GM 11-15 positions.

2. Background. The Office of Management and Budget (OMB) and Office of Personnel Management (OPM) have developed a program which will decrease the number of GS/GM 11-15 positions in the government by 2% in FY'85. Positions abolished at the GS/GM 11-15 level may be restructured and established at grades 1-10. To effect these reductions, OMB has withdrawn funds for these reductions from the Agency budget in Fiscal Year 1985. OPM will also monitor average grade and absolute reduction of GS/GM 11-15 employees.

3. Specific Targets Established. The Agency has established a single reduction goal for each Department and Staff Office. Targets were based upon the mathematical application of a 2% reduction in the number of GS/GM 11-15 positions as of March 31, 1984, plus projected additions for FY 1985. March 31, 1984, baseline figures reflect the 'on board' strength of full time permanent employees. (Vacant positions are not included.) Title 38, Federal Wage System, Canteen non-appropriated funds, temporary, part-time and intermittent positions are excluded from program controls. Grade 11-15 position ceilings have been established and will be monitored on a regional basis. A separate position ceiling has been established for Veterans Canteen Service which will be implemented and monitored by its Director.

4. Responsibility and Areas for Review. Regional Directors have the primary responsibility for ensuring that grade 11-15 position ceilings are established and met at facilities. Each Regional Director will develop a plan for implementing goals. It is intended that each region and facility have maximum flexibility in developing and carrying out programs and plans to meet grade 11-15 position ceilings. Medical Center Directors are responsible for achieving goals at the facility level. There are a variety of options available to you:

a. Evaluate all vacancies in the GS/GM 11-15 grade range to determine whether they can be eliminated or restructured at a lower grade level.

b. Closely monitor and manage career promotions. (Facilities must meet their local labor relations responsibilities.)

c. Review the organizational structure of each unit to determine if existing organizational patterns are appropriate.

THIS CIRCULAR EXPIRES ON NOVEMBER 19, 1985

d. Staff new programs in a manner that will tend to utilize fewer employees in the GS/GM 11-15 grade range.

e. Reorganize work where appropriate so that it can be accomplished with lower graded employees. For example, using technicians and program assistants where professional staff is not being utilized at their full skill level.

5. Evaluation. The PAID System will generate a report at the end of each quarter that will provide an analysis of the full-time permanent GS/GM 11-15 workforce at each facility. Regional Directors will use this report to monitor and evaluate regional progress in meeting program objectives.

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Chairman **Murkowski**. I wonder if you know of the 154 Chief Psychologists, and I guess there are about 1,200 Staff Psychologists, how many of the Chiefs and staff there are in each of the grades GS 11 through 15?

Dr. **Lips**. By percentage, or——

Chairman **Murkowski**. What kind of a proportion do we have?

Dr. **Lips**. I do not have those numbers available. I could provide them. However, I think it's important to understand that there is no such thing as a psychologist within the VA at less than a Grade 11. So, what we're talking about here is a proposal to re-engineer jobs. It would allow for bachelor's or master's trained psychology technicians to begin to provide services, since the qualification standards and the grading for doctorally-trained psychologists starts at a GS 11 level.

There is no way to do that except lowering the quality of health-care providers.

Chairman **Murkowski**. I understand your point. If you would provide that for the record.

Dr. **Lips**. Be happy to.

Chairman **Murkowski**. And also information on how many would be affected by the grade reduction.

Dr. **Lips**. The issue on how many psychologists will be affected by the grade reductions plan is not any information I could obtain. Basically, the plan for the agency at this time, as I understand it, is to freeze all positions in Grades 11 through 15 as they become vacant; creating an entirely attrition-based program. Such an arbitrarily implemented plan does not provide for good planning of health-care programs. If I were to lose a psychologist running a Vietnam veterans' program, my understanding is, at this point, that unless I received written permission from the Regional Director through appropriate channels, I would not be allowed to fill that position.

I would simply have to go with it vacant or promote someone and create another hole. There's absolutely no way of predicting, at this point, what the future will bring through the end of this fiscal year. It's my understanding that the Department of Medicine and Surgery still has somewhere in the vicinity of 400 positions to vacate in Grades 11 through 15.

If 400 psychologists were to leave I'm sure that that would take care of that number. However, it's hard to predict at this time which professionals, or other mid-level management will vacate their positions.

Chairman **Murkowski**. Thank you, Doctor.

[Subsequently, the American Psychological Association submitted the following information:]

Your first question dealt with the numbers of psychologists in each of the grade levels GS 11 through 15. Since psychologists are only employed in Grades 11 through 15, the following information is for the entire complement of psychologists in the VA's Department of Medicine and Surgery. The numbers, reflecting employment status as of January 1, 1985, follow:

Grade levels	11	12	13	14	15	Total
All psychologists [1]	62	90	1,131	117	36	1,447
Chiefs only [2]	1	1	44	82	26	154

[1] Source: VA quarterly report RCS 10-247

[2] Source: VA quarterly report RCS 10-245

You also asked how many psychologists will be affected by the grade and staff reductions proposed by the administration. These numbers are undeterminable. The implementation of the "plan" is dependent only upon positions becoming vacant; as a result each facility will be uniquely affected. A facility with a high vacancy rate for mid-level management personnel would be most likely to experience a devastating situation. However, a facility with a low attrition rate may still feel the effects of the implementation, if the majority of the vacancies occur in the same professional area. The lack of a rational approach by the Veterans' Administration to the implementation of the OMB and OPM plan is irresponsible.

The VA recognized early the detrimental effects that cutbacks would mean to their health-care delivery system when they exempted title 38 personnel (physicians, dentists, nurses, etc.) from the grade reduction proposal. We believe that this same rationale should be applied to all direct health-care service providers and the exemption extended to title 5 personnel. This would afford the VA the ability to continue to provide the quality and quantity of health care that has become its hallmark.

We hope that the Committee will act expeditiously to pass legislation that will exempt all direct health-care service providers in title 5, as well as those in title 38, from further staff and grade reductions. Short of this, we hope that the Committee will adopt the provision in Senate bill 6 that would give a considered and rational view to the VA grade reduction plans.

Chairman **Murkowski**. I've got to go up and vote on the Foreign Relations Committee to make a quorum. Senator Denton has joined us, and I'll ask if you would be kind enough to chair, if your time allows. If it doesn't, why, counsel here will preside, whatever accommodates your schedule.

Senator **Denton**. All right. I wish I could stay here all morning and hear this important hearing. We started at 9 in Armed Services on Soviet treaty violations. That is not over. It is important, I'm sure, to our veterans. I have two other hearings I'm supposed to be at this point.

Having read your statement and the statement of some of the witnesses, I would like to make my own statement at this point if I may, Mr. Chairman, and then make——

Chairman **Murkowski**. You may proceed, Senator.

Senator **Denton** [continuing]. Another point.

Chairman **Murkowski**. OK. Unless you got any questions of this panel, I would excuse it.

Senator **Denton**. No, no, that's fine.

I am pleased that we are holding hearings today to consider various pieces of legislation introduced for the purposes of improving future health care of our Nation's veterans. What we do now about those legislative initiatives may very well have a significant effect on the way that our veterans are cared for in the years ahead.

We are at a turning point. The plans now are going to be the basis for success, failures, advantages, disadvantages in the future. I want to address one aspect of our plans now.

My friend and colleague from Minnesota, Senator Boschwitz, and I have worked together to develop S. 1007, the Veterans' Health Care Promotion Act of 1985. We think that the bill is particularly appropriate now when we are concerned about providing adequate care for our veterans both in hospitals and in nursing homes, and also face increasing budgetary pressures.

We must keep our eyes on what is really important. I hope that our veterans are dismayed by the fact that President Reagan was elected on a mandate to continue improving our national defense, as we are behind the Soviets in ways I won't take up with you this morning, but that the Congress is cutting defense.

I believe most of you are familiar with how far behind we are. Maybe one example to the Navy veterans out there: When I was in the 6th Fleet in the Mediterranean, the total presence of the Soviets was two submarines. We had about 90 times as many ship-days in the Mediterranean as they did.

Now they're exceeding us in the Mediterranean in ship-days. We had 56,000 ship-days deployed in the early 1960's, in Kennedy's time, and they had 4,000 ship-days deployed in all the oceans of the world. About 10 to 1.

In 1979, after neglect of our Naval forces, they exceeded us in ship-days worldwide. A nation that is a land-based, a nation not requiring ships for its defense or its lines of communications, had more ship-days at sea than we did.

Yet the Congress has chosen to arrest our buildup in spite of the popular mandate, and we are in danger of cutting our veterans in a way that isn't fair. It's been done before in the history of this country, and we can't let it happen now.

If we're going to be reasonable and smart about this, we are going to have to deal with increasing budgetary pressures, and do what we can to save the quality of care for our veterans in the health field.

During the construction hearing last month, I talked about the advantages of acquiring suitable existing hospitals rather than building new ones at great cost. I have a parochial interest here. I have a lot of interest in Mobile, AL, where they have the Providence Hospital, which is only one-half block from where my mother lives.

She's lived in that house 50 years. My eldest son was born over there. I lived there half of my grade school and all of my high school time. So if I were to pretend to you that I don't have a parochial interest or a State interest in Providence Hospital, I'd be telling you an untruth. I do. But I do believe that the purchase of Providence Hospital is a step to getting better care sooner and at less cost by acquiring existing facilities. I've looked into that.

I won't stand up for a State interest or a city interest or a personal interest if I think the national interest suffers. In this case, I think the national interest greatly benefits. Senator Boschwitz and others agree, so we introduced this bill.

At least some of the service organizations that will or have testified this morning are inclined to oppose the bill for one reason or another by reason of their dislike for what is called mainstreaming. I don't like "mainstreaming" either.

The purchase of Providence Hospital would not have any part of mainstreaming. VA personnel would serve that hospital. It would not be throwing veterans on the mercies of a less caring and capable system.

I do hope that the service organizations will recognize, as the VA is beginning to recognize, that if the VA is to continue to provide the same quality of care for our veterans, it must find more cost-effective ways of acquiring hospitals and nursing home facilities without the loss of quality care.

I hope that the service organizations will carefully consider their position with respect to the issue in my State, and the bill that Senator Boschwitz and I have come up with, because you just can't proceed with business as usual and protect the quality and volume of care that our veterans need and deserve.

The budget crunch is going to get worse, not better. The OPM and other organizations have insisted for years that we should look at buying existing hospitals rather than building new ones with escalating costs. I think that now is a time to consider that in concrete terms and do it.

The number of veterans over age 65 is projected to increase to three times the current number by the next century. That will put a strain on the VA system as it currently exists, and is projected to exist. There's no way around it.

The cost to construct in every case a new VA medical facility is at least twice that of the private sector.

That isn't as bad as some of the Navy procurement problems we're going through, about which I've talked with Secretary Lehman. It's not the Navy's fault in most cases, nor is it the veterans' fault in any case, but it is taking, because of the bureaucratic situation, twice as much money to provide a new medical facility as it does if it's built by the private sector.

That situation is bad. It's not bad only because it's a waste of money, but because it deprives our veterans of the care that they could get, the care that they need and deserve. If there's another hospital similar to the one I'm talking about, I hope that we'll take a look at buying it if it was built very well and has met every criterion of quality care.

The VA yet does not have other options available to it. So far as I can see the bill would require the VA to consider the lease or purchase of existing medical facilities before developing plans for brandnew ones, whether as replacements or as additions to the system.

The VA already has the legal authority to look at lease or purchase, but it does not now do so, and it is reluctant to begin.

I will conclude by saying that if the pressures on the Federal budget increases, there is going to be great pressure to reduce the VA budget. We simply are not going to be able to afford new hospitals when we can get by purchasing older ones, ones that are just as good.

We're going to have to change our way of doing business if we're going to continue to serve our veterans in the way that they deserve. I would ask that my full statement be included in the record, Mr. Chairman. I also have a statement here, Mr. Chairman, for Senator Thurmond, which he asked me to submit for the record.

Mr. PRINCIPI [presiding]. Thank you, Senator.

[The prepared statements of Hon. Jeremiah Denton, a U.S. Senator from the State of Alabama; and Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina, follow:]

PREPARED STATEMENT OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

MR. CHAIRMAN, I AM PLEASED THAT WE ARE HOLDING A HEARING TODAY TO CONSIDER VARIOUS PIECES OF LEGISLATION INTRODUCED FOR THE PURPOSES OF IMPROVING THE FUTURE HEALTH CARE OF OUR NATION'S VETERANS. WHAT WE DO ABOUT THOSE LEGISLATIVE INITIATIVES MAY VERY WELL HAVE A SIGNIFICANT EFFECT ON THE WAY THAT OUR VETERANS ARE CARED FOR IN THE YEARS AHEAD.

MY FRIEND AND COLLEAGUE FROM MINNESOTA, SENATOR BOSCHWITZ, AND I HAVE WORKED TOGETHER TO DEVELOP ONE SUCH PIECE OF LEGISLATION, S. 1007, THE "VETERANS HEALTH CARE PROMOTION ACT OF 1985." WE BELIEVE THAT THE BILL IS PARTICULARLY APPROPRIATE AT A TIME WHEN WE ARE CONCERNED ABOUT PROVIDING ADEQUATE CARE FOR OUR VETERANS, BOTH IN HOSPITALS AND IN NURSING HOMES, BUT FACE INCREASING BUDGETARY PRESSURES.

DURING THE CONSTRUCTION HEARING LAST MONTH, I TALKED ABOUT THE ADVANTAGES OF ACQUIRING SUITABLE EXISTING HOSPITALS RATHER THAN BUILDING NEW ONES AT GREAT COST. I

USED PROVIDENCE HOSPITAL IN MOBILE, ALABAMA, AS AN EXAMPLE OF HOW WE COULD GET BETTER CARE SOONER AND AT LESS COST BY ACQUIRING EXISTING FACILITIES. THAT PARTICULAR SITUATION IS ADDRESSED IN THE BILL THAT SENATOR BOSCHWITZ AND I INTRODUCED.

I UNDERSTAND THAT AT LEAST SOME OF THE SERVICE ORGANIZATIONS THAT WILL TESTIFY THIS MORNING ARE INCLINED TO OPPOSE OUR BILL FOR ONE REASON OR ANOTHER, BY AN LARGE BECAUSE OF THEIR DISLIKE OF WHAT IS CALLED "MAINSTREAMING." I JUST HOPE THAT THE SERVICE ORGANIZATIONS WILL RECOGNIZE THAT, IF THE V.A. IS TO CONTINUE TO PROVIDE THE SAME QUALITY OF CARE FOR OUR VETERANS, IT MUST FIND LESS EXPENSIVE AND MORE COST-EFFECTIVE WAYS OF OF ACQUIRING HOSPITAL AND NURSING HOME FACILITIES.

I HOPE THAT THE SERVICE ORGANIZATIONS WILL CAREFULLY CONSIDER THEIR POSITION, BECAUSE IN MY STATE, AT LEAST, THE VETERANS WOULD OVERWHELMINGLY PREFER THAT THE V.A. PROCEED ALONG THE LINES THAT SENATOR BOSCHWITZ AND I HAVE SUGGESTED, NOT ALONG THE LINES OF "BUSINESS AS USUAL."

THE BUDGET CRUNCH IS GOING TO GET WORSE, NOT BETTER. PERHAPS WE HAVE BEEN SPOILED BY A SITUATION IN WHICH ALL OUR HOSPITALS AND NURSING HOMES ARE NEW CONSTRUCTION OF THE

FINEST SORT. I OBSERVE SIMPLY THAT WE CANNOT EXPECT THAT SITUATION TO CONTINUE, NO MATTER HOW MUCH WE WOULD LIKE IT. ALTHOUGH I THINK THAT IT IS GREAT ALWAYS TO GET A BRAND NEW FACILITY, WHEN PUSH COMES TO SHOVE I WOULD RATHER ENSURE THAT THERE IS ADEQUATE CARE FOR OUR VETERANS IN ADEQUATE FACILITIES, PARTICULARLY IF THE ALTERNATIVE IS CARE PROVIDED IN LESSER AMOUNTS TO FEWER VETERANS IN A SMALLER NUMBER OF HIGH-COST FACILITIES.

THE NUMBER OF VETERANS OVER AGE 65 IS PROJECTED TO INCREASE TO THREE TIMES THE CURRENT LEVEL BY THE NEXT CENTURY. THAT SITUATION WILL PUT A STRAIN ON THE V.A. SYSTEM AS IT CURRENTLY EXISTS AND AS IT IS PROJECTED TO EXIST. FOR VARIOUS REASONS, THE COST TO CONSTRUCT A NEW V.A. MEDICAL FACILITY IS AT LEAST TWICE THAT OF THE PRIVATE SECTOR, AND IT TAKES MUCH LONGER. TO ME, THAT SITUATION IS INEXCUSABLE, NOT ONLY BECAUSE IT MAY WELL BE A WASTE OF MONEY BUT BECAUSE IT DEPRIVES OUR VETERANS OF THE CARE THAT THEY NEED AND DESERVE.

THE SITUATION IS ALL THE WORSE BECAUSE THE V.A. DOES HAVE OTHER OPTIONS AVAILABLE TO IT. OUR BILL WOULD REQUIRE THE V.A. TO CONSIDER THE LEASE OR PURCHASE OF EXISTING MEDICAL FACILITIES BEFORE DEVELOPING PLANS FOR NEW NEW ONE, WHETHER AS REPLACEMENTS OR AS ADDITIONS TO THE SYSTEM. THE

V.A. ALREADY HAS THE LEGAL AUTHORITY TO LOOK AT LEASE OR PURCHASE, BUT IT DOES NOT NOW DO SO AND IS RELUCTANT TO BEGIN.

AS THE PRESSURE ON THE FEDERAL BUDGET INCREASES, THERE IS GOING TO BE GREAT PRESSURE TO REDUCE THE V.A. BUDGET. WE SIMPLY ARE NOT GOING TO BE ABLE TO AFFORD NEW, FANCY HOSPITALS. WE ARE GOING TO HAVE TO CHANGE OUR WAY OF DOING BUSINESS IF WE ARE GOING TO SERVE OUR VETERANS.

IN SOUTH ALABAMA AND ADJACENT AREAS, THE VETERANS CAN WAIT AT LEAST NINE YEARS, AND PERHAPS EVEN MORE, FOR A NEW HOSPITAL, OR THEY CAN HAVE ONE IN TWO YEARS IF THE V.A. PURCHASES A PERFECTLY ADEQUATE EXISTING FACILITY. THE VETERANS WHO TALK TO ME SAY THAT THEY PREFER THE EXISTING FACILITY, BECAUSE IT WILL GIVE THEM CARE NOW, WHEN THEY NEED IT, INSTEAD OF MANY YEARS FROM NOW WHEN THEY MAY NO LONGER BE AROUND TO ENJOY THAT NEW HOSPITAL -- IF THAT NEW HOSPITAL IS BUILT AT ALL.

FRANKLY, MR. CHAIRMAN, I THINK THAT VETERANS AROUND THE COUNTRY WOULD REACT IN THE SAME WAY IF PRESENTED THE SAME CHOICE. THE V.A. NEEDS TO PUT ITS RESOURCES INTO PROVIDING EFFECTIVE AND TIMELY CARE, NOT ON BUILDING NEW, HIGH-COST

HOSPITALS THAT MANY OF TODAY'S VETERANS WILL NOT BE ABLE TO USE.

MR. CHAIRMAN, I HOPE THAT THE SERVICE ORGANIZATIONS WILL CONSIDER THE MATTER CAREFULLY. I HOPE THAT MY COLLEAGUES WILL DO THE SAME AND SUPPORT THE BILL. I AM CONFIDENT THAT THE PILOT PROGRAM FOR WHICH IT PROVIDES WILL BE SUCCESSFUL, AND THAT IT WILL SET US ON A COURSE THAT WILL BENEFIT VETERANS IN EVERY STATE THROUGHOUT OUR COUNTRY. IT WILL DEMONSTRATE THAT WE CAN PROVIDE BETTER SERVICE TO OUR VETERANS BY ADOPTING INNOVATIVE APPROACHES TO ACQUIRING HEALTH CARE FACILITIES.

MR. CHAIRMAN, I LOOK FORWARD TO LEARNING THE VIEWS OF THE WITNESSES TODAY. I SHALL READ THE HEARING RECORD WITH GREAT INTEREST.

THANK YOU, MR. CHAIRMAN.

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

MR. CHAIRMAN:

It is a pleasure to be here today to receive testimony on various legislative proposals pertaining to veterans' health care programs.

Mr. Chairman, I want to commend you on the fine job you are doing as Chairman of the Senate Committee on Veterans' Affairs as we work to improve and enhance the programs and services provided to the Nation's deserving veterans.

In view of the necessity of reducing the soaring Federal budget deficit, this Committee faces the difficult challenge of weighing competing demands for limited resources. For this reason, proper health care planning and the efficient delivery of medical services have never been more important to ensure that the Nation's commitment to our veterans is met through the provision of quality medical care.

Mr. Chairman, the legislation which will be considered by the Committee today seeks to address very important issues in the area of veterans' health care. Among the proposals are initiatives pertaining to the planning process for the construction of VA medical facilities; noninstitutional forms of health care services as alternatives to nursing home care; treatment for alcoholism and drug dependence; and community residential care for chronically mentally ill veterans. Also, I am particularly interested in the testimony we will receive today concerning the proposal to establish a pilot program of Vietnam Veteran Resource Centers, which will examine a new concept in providing services to Vietnam veterans.

Mr. Chairman, another bill which will be considered at this hearing is S. 1052, which I introduced. This legislation will authorize the Veterans Administration to conduct demonstration projects for the purposes of providing chiropractic services to eligible veterans and evaluating the therapeutic benefits and cost-effectiveness of such services. The Senate passed similar legislation during the 96th, 97th and 98th Congresses, but the House of Representatives failed to accept this initiative. It is my strong belief that our Nation's veterans deserve the same access to medical treatment, including chiropractic care, which is enjoyed by the beneficiaries of many other Federal and State health care programs. I am particularly interested in the comments of the several witnesses on this legislation.

Mr. Chairman, we have a distinguished list of witnesses who are with us today, and I look forward to a careful review of their testimony.

Mr. PRINCIPI. The committee will receive testimony from Mr. David Baine, Associate Director, accompanied by Mr. Norm Rabkin, Group Director; Mr. Bob Garbark, and Mr. Jesse Flowers, General Accounting Office.

TESTIMONY OF DAVID P. BAINE, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY NORM RABKIN, GROUP DIRECTOR; BOB GARBARK, AND JESSE FLOWERS

Mr. Baine. Thank you, sir.

We are glad to be here today to discuss the results of our review requested by this committee on the VA's health-care quality assurance systems and procedures.

This morning we will discuss the makeup of the VA's quality assurance systems and the degree to which they were implemented at 13 VA medical centers we visited. We will also discuss the quality assurance activities of several central office organizations. We have prepared a draft report on our work and submitted it to the VA for comment. We expect their comments within a week or so.

In this review we concentrated on establishing a baseline of information concerning the status of VA's implementation efforts. VA's formal quality assurance program has two primary focuses. First, each medical center is required to review the quality of care provided to its patients. Second, VA's central office reviews the quality of care provided by its medical centers and determines the effectiveness of their quality assurance programs.

VA regulations require medical centers to implement five specific activities to assure that quality of care is being provided. We found the medical centers' formal assurance programs to be rather limited in scope and in only partial compliance with VA's quality assurance regulations. None of the medical centers we visited fully complied with the regulations.

As a result, the centers did not always, one, determine whether the health-care services provided were appropriate to patient needs; two, determine patterns and trends of medical care provided; and, three, resolve systemic quality of care problems.

Medical center officials with whom we spoke did not view their noncompliance with VA's regulations as a major problem. Although the regulations are mandatory, some center officials interpreted them as allowing flexibility in the nature and content of their facility's formal quality assurance program, and the exclusion of certain quality assurance functions that they perceived were unnecessary.

Because we did not evaluate the effectiveness of the total range of the medical centers' quality assurance activities, we cannot conclude, nor should anybody conclude, that their lack of total compliance with VA's requirements resulted in poor quality of care. However, where quality assurance activities were not performed, neither VA's central office nor the medical centers themselves can be sure that patients receive optimum care.

Until the recent reorganization of VA's central office quality assurance functions, VA's medical inspector was responsible for overseeing medical centers' quality assurance programs. The medical inspector reviewed the quality of care and the quality assurance programs of each medical center through the systematic external review program.

From our discussions with VA officials and our analysis of the external review process, we found that, one, external reviews have not evaluated the effectiveness of the medical centers' quality assurance programs; two, the medical inspector had not conducted the number of external reviews he had planned to conduct; and, three, some team members and medical center officials believed that the timeframe for conducting reviews is too short.

The medical inspector has been and will continue to be responsible for investigating specific allegations or incidents of perceived poor quality of care. These investigations are initiated when incidents should have been investigated at the medical centers but were not, medical center investigations are found to be inadequate or allegations of poor quality of care appear to have merit.

The Inspector General at VA oversees the medical inspector's investigation activities. To accomplish these responsibilities the Inspector General has assigned a member of his staff to review the medical inspector's investigations to assure that they are adequate. In November 1982, the Inspector General recommended a more formal relationship between himself and the medical inspector. In December 1984, the Inspector General and Chief Medical Director signed an agreement to formalize this relationship.

This concludes my summary, Mr. Chairman. I would appreciate it if the full statement would appear in the record.

Mr. PRINCIPI. Thank you, Mr. Baine. Your statement will appear in the record.

[The prepared statement of David P. Baine, Associate Director, Human Resources Division, General Accounting Office, follows:]

PREPARED STATEMENT OF DAVID P. BAINE, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. Chairman and Members of the Committee:

We are pleased to be here this morning to discuss the results of our review--requested by this Committee--of the Veterans Administration's (VA's) health care quality assurance systems and procedures.

This morning we will discuss the makeup of VA's quality assurance systems and the degree to which they were implemented at the 13 VA medical centers we visited. We will also discuss the quality assurance activities of several central office organizations. We have prepared a draft report on the results of our work and have sent it to VA for comment. As requested by your office, we also provided the Committee a copy of the draft report.

OBJECTIVES OF OUR REVIEW

Our objectives were to

--determine whether VA medical centers had the quality assurance mechanisms and procedures required by VA's regulations,

--describe the roles of other VA organizational units in assuring the quality of care in the medical centers, and

--answer several specific questions raised by the Committee.

At the 13 medical centers we visited and VA's central office, we interviewed staff members responsible for implementing the quality assurance program and reviewed documents that indicated the degree to which VA's quality assurance procedures were being implemented. We did not, in this review, evaluate the effectiveness of VA's quality assurance activities. Rather, as the Committee requested, we concentrated on establishing a baseline of information concerning the status of VA's program implementation efforts.

VA'S QUALITY ASSURANCE PROGRAM

One of VA's primary goals is to assure that quality medical care is provided on a timely basis to all eligible veterans.

VA's quality assurance program was designed to objectively and systematically evaluate VA's total health care activities with an emphasis on patterns of care rather than individual cases or clinicians.

VA's formal quality assurance program has two primary focuses. First, each medical center is required to review the quality of care provided to its patients (VA calls this a systematic internal review--SIR). Second, VA's central office reviews the quality of care provided by its medical centers and determines the effectiveness of their quality assurance programs (VA calls this its systematic external review program--SERP). In addition to this formal program, each medical center uses day-to-day management of staff and oversight of activities, as well as external reviews by the Joint Commission on the Accreditation of Hospitals and others, to assure that its patients receive high quality care.

VA's Chief Medical Director is responsible for implementing, maintaining, and enforcing VA's quality assurance program requirements. He relies primarily on medical facility directors to meet the agency's objectives of providing high quality medical care. Until early March 1985, VA's Medical Inspector and Evaluation Office, headed by VA's Medical Inspector, provided the principal central office policy and oversight assistance to the Chief Medical Director in the quality assurance area.

To provide increased emphasis on VA's quality assurance program, the Chief Medical Director, on March 3, 1985, placed the central office quality assurance evaluation functions in a newly created Office of Quality Assurance. The central office investigative functions remained with VA's Medical Inspector. In addition, VA's Inspector General also contributes to the agency's quality assurance activities through facility evaluations, program reviews, and oversight of the Medical Inspector's investigations.

MEDICAL CENTERS HAD NOT IMPLEMENTED QUALITY ASSURANCE PROGRAMS AS REQUIRED

VA's regulations require medical centers to implement five specific activities to assure that quality care is being provided:

--Continuous monitoring: A systematic review of 15 clinical elements that are key indicators of the quality of care being provided. These elements include reviews of medical records, examination of surgical case tissues, and analysis of morbidity and mortality rates.

--Patient injury control: A program for medical staff to report and investigate incidents (such as patient abuse and medication errors) resulting during a patient's stay.

--Utilization review: Clinical and administrative screening and studies to assure that resources are appropriately used.

--Problem-focused health care studies: Multidisciplinary studies of complex clinical problems affecting patient care.

--Credentialing and delineation of clinical privileges: A systematic means to review the qualifications of all applicants and current staff to assure they have the necessary professional capabilities for the particular diagnostic and therapeutic procedures for which they will be responsible.

The quality assurance programs at the 13 VA medical centers we reviewed included efforts to (1) establish policies regarding the provision of quality health care, (2) hire quality health care providers, and (3) identify and resolve health care problems through day-to-day oversight and specific reviews of care and services provided. However, we found the medical centers' formal quality assurance programs to be limited in scope and only in partial compliance with VA's quality assurance regulations.

None of the medical centers fully complied with the regulations. As a result, the centers did not always (1) determine whether health care services provided were appropriate to patient needs, (2) determine patterns and trends of medical care provided, and (3) resolve systemic quality of care problems. Medical center officials generally did not view their noncompliance with VA's regulations as a problem. Although the regulations are mandatory, some center officials interpreted them as allowing (1) flexibility in the nature and content of their facilities' formal quality assurance programs and (2) exclusion of quality assurance functions, elements, or task analyses that they perceived as unnecessary.

Because we did not determine the effectiveness of the total range of the medical centers' quality assurance activities, we cannot conclude that their lack of total compliance with VA's requirements resulted in poor quality care. Nor is it appropriate to conclude that total compliance with the regulations would necessarily assure good quality care. However, where quality assurance activities are not performed, neither VA's central office nor the medical centers can be sure that patients receive optimum care.

VA'S EVALUATION OF MEDICAL CENTERS' QUALITY ASSURANCE PROGRAMS

Until the recent reorganization of VA's central office quality assurance functions, VA's Medical Inspector was responsible for oversight of medical centers' quality assurance programs. The Medical Inspector reviewed the quality of care and the quality assurance programs of each medical center through VA's systematic external review program. This program involves week-long evaluations of medical care and related services by a team of health care and administrative personnel from other medical centers headed by a member of the Medical Inspector's staff. The team uses a standard methodology and issues a report on its findings.

From our discussions with VA officials and our analysis of the external review process, we found that (1) external reviews have not evaluated the effectiveness of the medical centers' quality assurance programs, (2) the Medical Inspector had not conducted the number of external reviews he had planned to conduct, and (3) some team members and medical center officials believe that the time frame for conducting reviews is too short.

The Medical Inspector has been and will continue to be responsible for investigating specific allegations or incidents of perceived poor quality care. Medical facility officials are required to report to the Medical Inspector information on incidents ranging from falls or medication errors to unexpected deaths and suicides. They are also required to investigate certain types of incidents, such as unexpected deaths, transfusion accidents, and report the results to the Medical Inspector.

The Medical Inspector initiates investigations when (1) incidents should have been investigated at the medical centers but were not, (2) medical center investigations are found to be inadequate, and (3) allegations of poor quality care appear to have merit. Medical Inspector investigations may consist of having personnel at the medical center provide additional information concerning incidents, requiring medical centers to conduct investigations, or making site visits to the involved facilities. In fiscal year 1984, the Medical Inspector initiated 199 investigations, 17 of which resulted in site visits by him or a team he selected.

THE INSPECTOR GENERAL'S QUALITY ASSURANCE ACTIVITIES

VA's Inspector General receives allegations of fraud, waste, and mismanagement from his telephone "hotline" and other sources; reviews each; and investigates those that appear to have merit. He refers allegations regarding perceived instances of poor quality care to the Medical Inspector.

The Inspector General also oversees the Medical Inspector's investigation activities. To accomplish these oversight responsibilities, the Inspector General has assigned a member of his staff to review the Medical Inspector's investigations to assure they are adequate. In November 1982 the Inspector General recommended a more formal relationship between himself and the Medical Inspector. In December 1984 the Inspector General and Chief Medical Director signed an agreement to formalize the relationship.

The Inspector General also conducts audits to determine whether VA medical centers are operating efficiently and economically and in accordance with applicable laws and regulations. Beginning in fiscal year 1984 these audits began addressing aspects of the medical centers' quality assurance programs, such as tracking implementation of recommendations to improve quality of care. In addition to facility audits, the Inspector General periodically conducts special program reviews covering various quality assurance matters.

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Mr. Chairman, section 5 of S. 876, which you recently introduced, together with the recent changes in VA's quality assurance program announced by VA's Chief Medical Director, should help increase VA's emphasis on its formal quality assurance activities that were the focus of our review. This concludes my prepared statement. We will be happy to answer questions you or the other members may have.

Mr. **Principi**. I do have a few questions, and then I'll turn it over to Mr. Steinberg.

In your statement you indicate that the VA has received the draft report of the result of the review. Have they commented on the review, either officially or unofficially?

Mr. **Baine**. No, sir; they have not. We expect their formal comments I believe this week.

Mr. **Principi**. You found that 13 medical centers were reviewed and none had implemented all the quality assurance programs as required. Were they in substantial compliance, minimal compliance? How would you characterize their compliance program?

Mr. **Baine**. I will let Mr. Flowers elaborate on this.

I think our overall judgment was that the medical centers were doing some portions of the quality assurance programs and were not doing others. I think we would judge that they were in partial compliance with most of the quality assurance regulations.

Mr. **Flowers**. I think that's a fair statement.

Most all of the centers were doing certain things that could be interpreted as quality assurance type activities. They were carrying out day-to-day management oversight. They were using various external reviews and certain types of review activities. However, they were not carrying out the specific quality assurance-type activities as prescribed in VA's regulations, and therefore, most of them were, in our opinion, in partial compliance.

Mr. **Principi**. They indicated their noncompliance was not a problem. In what sense did they state that it's not a problem?

Mr. **Flowers**. Not a problem because of the other activities that they were carrying out. They thought those activities actually met the intent or the spirit of the regulations.

Mr. **Principi**. Did you inquire of VA central office officials whether they viewed it as a problem?

Mr. **Flowers**. Yes; we did, and I think for the most part they did view it as a problem.

Mr. **Principi**. On page 40 of your report you state that, "More could be done to analyze quality assurance data compared to standards and identify trends." Could you discuss your findings with respect to what activities the VA does have at both the medical center level and at the central office level for analyzing quality of care patterns and trends and what additional acitivites could be done in this area?

Mr. **Baine**. Again, let me summarize our answer and I can refer to Mr. Flowers and Mr. Garbark.

It was our feeling that the determination of patterns and trends of health care at both the centers and the central office was lacking. We were told at the medical centers that this is done through the normal day-to-day management of the medical center and really was not part of the quality—or was not viewed as part of the quality assurance program.

We did not see an awful lot of evidence, sir, of the determination of patterns and trends in the sense that one would normally think that they would be developed.

Mr. **Garbark**. Let me add, within the quality assurance program at the central office we didn't find any particular standards being used or trend analysis being conducted other than within the office that conducts SERP reviews. They did compile the results of SERP reviews and JCAH reviews—that is, their recommendations and findings—and did some kind of analysis on those.

But, other than that, we found no analysis being conducted nor did we see that much at the medical centers we visited. I believe a few may have performed trend analyses. At least one medical center did The others weren't doing much at all in that area, nor were standards visible at the medical centers we visited.

Mr. **Principi**. Could you comment on the extent to which those quality care problems which are recorded and identified by medical centers are actually tracked to assure the resolution of the problem?

Mr. **Garbark**. We did find at the medical centers we visited that they were tracking, to a reasonable extent, recommendations to see if they were implemented. Although it is a responsibility of the regional offices to follow up to make sure these recommendations are implemented, we didn't see a whole lot of activity on the part of the regional offices.

Nevertheless, the recommendations do seem to be implemented for the most part. There is a reasonable amount of seriousness within the medical centers in regard to implementing recommendations.

Mr. **Principi**. On page 32 of your report you state that:

> The systematic external review process [SERP] does not assess how the credentialing reviews are conducted or the basis for the delineation of clinical privileges.

Throughout your review process what were you able to find out about the VA's process for reviewing the credentials of VA physicians?

Mr. **Baine**. I believe it was our impression, sir, that the credentialing process was primarily conducted at the medical centers by the executive committees and credentialing committees.

Mr. **Flowers**. I think that Mr. Baine's comment is correct. Credentialing and delineation of privileges is done at the medical centers. The practice that we saw generally was—when a physician applied or a medical staff member applied for appointment to a center, usually the service chief or someone responsible would call the location from where the person was coming and inquire about what kind of experiences that person had.

Beyond that we didn't see a lot of detailed analyses of what kind of experiences, or what kind of batting average a person had

Mr. **Principi**. In other words, there was really no systematic check of the doctors' credentials with the various States that the doctor was licensed to practice medicine in.

Mr. **Flowers**. What was done varied from one center to another.

Mr. **Principi**. I read yesterday that the VA has a proposed notice or regulation in the Federal Register whereby the inspector general is going to be looking, by doing a computer check of VA physicians based upon their licensing in various States. Is that an outgrowth of any of your recommendations or is that something that was discussed with you all?

Mr. **Garbark**. I think that might be an outgrowth of the hearings that were conducted last June. I believe the IG's activities are a result of those hearings and the concern expressed by this committee and others about quality of care.

Mr. **Principi**. On pages 37 and 38 of your report you stated that:

> The VA began a quality assurance manual which was sent to the medical inspector for review in September 1983 and that as of March of this year the revised manual had not been issued.

You also stated that:

> The medical inspector was preparing a program guide to assist medical centers in setting up a quality assurance program and that this guide had not been finalized as of March of this year.

Do you believe that there is a need for uniform VA-wide criteria to aid the medical centers in implementing the quality assurance programs?

Mr. **Baine**. I would say that, yes, there is a need, sir. I think it's important that VA put itself in the position—and I think it has worked very hard to do this that it can assure itself that it has the systems in place to provide high quality of care. The kinds of things that you were talking about in terms of guidelines and standards from the central office to assist the medical centers should be put in place. I think that would be most helpful.

Mr. **Principi**. One final question.

In your opinion, does the VA have sufficient resources to perform its external review function?

Mr. **Baine**. VA felt it had about the right number of human resources to carry out the systematic external review process. However, they also felt that they did not have the proper amount of travel money to conduct those reviews and, therefore, they did not conduct as many external reviews as they had planned to conduct.

Bob.

Mr. **Garbark**. Yes, that is true. The SERP Program has not had sufficient travel money to do the number of visits that they'd like to do. On the other hand, the investigation activities have had enough funding and enough staff to conduct their activities. Both activities were under the same office.

Mr. **Principi**. Thank you very much, gentlemen.

Jon.

Mr. **Steinberg**. Thank you, Tony.

On page 2 of your testimony you state, "We did not in this review evaluate the effectiveness of VA's quality assurance activities," and at other places in the testimony you indicate that having not done that, it is impossible to assert with any degree of certainty whether or not, had the facilities complied with the rules and regulations, that would have provided greater quality assurance.

What are your plans to proceed to make that evaluation so that the committee can have a much better actual assessment of the relationship between the VA's performance and actual quality assurance?

Mr. **Baine**. Mr. Steinberg, we saw this effort—in addition to answering the committee's questions concerning the quality assurance system—as an effort which would provide us a baseline of information from which to proceed into the quality assurance area in more depth.

As we now have planned it, what we expect to do is to take individual aspects of the quality assurance program, such as patient injury control, credentialing and other individual aspects, and try to develop a methodology where we can say more definitively whether this aspect of the quality assurance program is in fact working effectively and, if not, why not and so what.

Mr. **Steinberg**. In doing that are you going to consult closely with the Department of Medicine and Surgery's Quality Assurance Office?

Mr. **Baine**. We certainly will.

Mr. **Steinberg**. I think it would be useful and I would hope that you would concur in this, Tony, for the GAO—perhaps beginning a year from now, after the new quality assurance mechanism that the chief medical director is establishing has had an opportunity to be put in place to—having developed those criteria, take a look at, No. 1, the extent of compliance with the criteria, and then, No. 2, what actually is being accomplished in the area of quality assurance. It would seem to me that to do any study now, while a new or a relatively new process is being put in place, would not be very productive.

Would you agree with that?

Mr. **Baine**. I believe, Mr. Steinberg, that to take individual aspects of the quality assurance program, such as patient incident reporting or the credentialing aspect, would, in fact, provide this committee and others some useful information about those elements of the quality assurance program.

My sense is that those elements are going to be there. They're fairly fundamental elements of any quality assurance program.

It's our understanding that the inspector general of the VA is now involved in reviewing the credentialing aspect of the quality assurance program. We had talked with the inspector general. We have also talked with people from the Department of Medicine and Surgery and chose to take the patient injury control segment as the next one to try to get a handle on where we can develop the methodology to be able to say whether it is effective and so what.

I personally think that those kinds of endeavors within the next year would still be useful.

Mr. **Steinberg**. In any event, I take it that you would be satisfied before you proceed that any particular aspect to the program that you are studying is one that is in place rather than one that is in flux so that we are not studying something before it is established?

Mr. **Baine**. Yes.

Mr. **Steinberg**. I am wondering if you have any suggestions that you wish to make to the committee now or in writing for any modifications or refinements in the language of section 5 of S. 876 which you seem to have generally endorsed?

Mr. **Baine**. We would be glad to provide that in writing. It was our sense, Mr. Steinberg, that section 5 of the chairman's bill continues to provide an emphasis on the quality assurance system that it was our perception that the VA was also providing. We would be happy to provide written comments on specific aspects of that provision as soon as possible.

Mr. **Steinberg**. I think that you might want to do that taking into account the prepared statement of the Veterans' Administration with respect to section 5.

Mr. **Baine**. Yes, sir.

Mr. **Steinberg**. Finally, is it your assumption, and you may wish to answer this in writing as you look at section 5 more closely, but is it your assumption in analyzing and expressing general support for section 5 that the data collected on mortality and morbidity would be a matter of public information?

Mr. **Baine**. It was our assumption that it would, I believe, sir.

Mr. **Steinberg**. Thank you. Thank you for your testimony.

Mr. **Principi**. I just have two additional questions.

In addition to the credential's computer check, what other activities are ongoing by the inspector general?

Mr. **Baine**. The inspector general does individual facility audits about once every 3 years. Some aspects of the quality assurance program are reviewed at that time. In addition, within the last year, the inspector general has had special program emphasis in the quality assurance area.

As I mentioned to you before, the inspector general is currently looking at the credentialing process. That is one of the reasons that we are not. And the inspector general's office is also looking at the malpractice area in VA.

Mr. **Principi**. And one final question.

Do you support the chairman's provision in S. 876 relative to quality assurance? Do you have any views on it?

Mr. **Baine**. Generally, yes, we do. Again as I mentioned to Mr. Steinberg, it is our feeling that this continues an emphasis in an area that needs an emphasis. And I am quite confident that it is also an area where VA has placed a good deal of increasing emphasis in the last year.

Mr. **Principi**. Thank you, gentlemen. We appreciate your testimony. On behalf of the chairman, thank you for your report as well.

The committee will now receive testimony from Mr. Paul Egan of The American Legion; Mr. Donald Schwab of the VFW; and Mr. David Gorman of the Disabled American Veterans. Gentlemen. Mr. Egan.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF: PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. **Egan**. Thank you. As always, we appreciate the opportunity to be here. The subject matter of this hearing is rather extensive, so we will take up the legislation in the order that it was introduced.

First of all, in S. 6 beginning with section 3 which would prevent further reductions in the grade levels GS-11 through 15, particularly with regard to title 38 employees, we support that provision. And if there is no objection, I would like to add for the record a document that we have assembled containing excerpts from 26 VA medical centers surveyed in Legion field reports over the last 14 months, all of which describe the increasing problems that are resulting from the OMB GS-11 through 15 initiative.

Section 4 of S. 6 would extend health eligibility for those individuals exposed to agent orange or radiation until September 30, 1989. We agree with that given the delay in the final results of the agent orange study. Section 6 would exclude income earned in rehabilitation or therapy from income for pension purposes. We agree with that.

Section 7 would provide the availability of statistics disclosing aggregate morbidity and mortality, and we think that is needed.

Historically, we always supported the idea of providing for confidentiality throughout the peer review process. But we never intended for that confidentiality to be used as a blanket excuse to withhold information that should otherwise be available to the general public.

Section 8 would confer due process rights for health-care professionals found to be deficient in their ability to deliver health care. We find that provision to be acceptable. However, we do believe that during the period that the appeals process is going on, we think the VA should have the authority to remove those professionals from direct hands-on health care until final disposition of the case.

Section 9 would establish a 48-month pilot project to evaluate noninstitutional care. And that would include three geriatric evaluation units. We think this is a good idea, and we support it.

Section 10 would provide for a report on how to address the agent orange exposure and PTSD problems found in nonmilitary personnel having served in Vietnam as volunteers. We agree with this.

Turning to the chairman's bill, S. 876, the second provision authorizes a 5-year pilot project providing medical rehabilitation and social services as alternatives to nursing home care. We agree with this provision.

Section 3 would make the pilot program on alcohol and drug abuse permanent. We find that to be a good idea. However, we would suggest that there be a limit of say 1 year on the period of followup of those individuals simply because after a certain amount of time, we believe that some conclusion has to be made on whether the individual has or has not recovered from the problems for which he sought treatment.

Section 4 of that legislation would establish a pilot program for community residential care for chronically mentally ill. The VA would be authorized to pay for that care, and report after 18 months on how that pilot program was operating.

We find that to be a good idea, but we want to emphasize that followup of those patients referred to the community residential facilities or community mental health facilities is critically important done to assure that these veterans do not join the ranks of those homeless individuals that have been growing over the last several years.

The fifth section would establish a quality assurance program. We agree with this. Section 6, establishes an advisory committee on facility planning. We agree with that.

With regard to Senator Denton's and Senator Boschwitz' legislation, we suggest that the ideas raised in that legislation be included in the subject matter under study by the advisory committee contemplated in Chairman Murkowski's bill, S. 876.

I see that I've run out of time. We've provided a rather extensive statement. We would certainly draw the full text to your attention since we have expressed ourselves regarding all of the other legislative matters before the committee's consideration.

Mr. PRINCIPI. Thank you, Mr. Egan.

[The prepared statement of Paul S. Egan, Deputy director, National Legislative Commission, and John F. Sommer, Jr., Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion, follows:]

PREPARED STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AND JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

We thank you for the opportunity to present The American Legion's views on several legislative measures under the Committee's consideration today, both of which pertain to issues relating to the health care of veterans.

Mr. Chairman, we shall first offer comment on -

S. 6 - "Veterans' Administration Health Care Amendments of 1985."

Section 2 of the measure would amend section 101(29) of title 38, United States Code, to expand the definition of the Vietnam era to include service in Vietnam at any time during the period beginning on February 21, 1961, and ending on August 4, 1964, the day before the starting date of the Vietnam era under current law.

Mr. Chairman, The American Legion currently has this issue under study, and therefore will not offer comment on section 2 at this time.

Section 3 of the bill would amend section 210(b) of the title to preclude the Administrator of Veterans Affairs from implementing any systematic reduction of VA employee pay grades without first submitting to the Senate and House Veterans Affairs Committees a plan and justification for the proposed reduction, including a determination that, in the personnel area involved, the Veterans

Administration, in comparison to other departments and agencies of the Federal Government and non-Federal employers, has a disproportionate number of employees at the salary levels involved. This section would also direct the Comptroller General of the United States to evaluate the Administrator's comment on any such plan and report to the Committees on Veterans Affairs on the Administrator's compliance with the proposed law, and the accuracy of VA comment on the justification and determination of any plan of this nature.

The American Legion is firmly in support of the intent of this section, which would protect the Veterans Administration and particularly the Department of Medicine and Surgery, from the disastrous consequences of the ongoing GS 11-15 grade reduction initiative that we anticipate befalling the VA medical care system in the very near future, unless corrective action is taken.

National Commander Clarence M. Bacon expressed the concerns of The American Legion on this issue in his statement to this Committee on September 18, 1984. At that time, National Commander Bacon cautioned the Committee that the Legion had assessed the impact of the initiative on the operation of DM&S, and that we were satisfied that the consequences to follow would be disastrous to the ability of VA to provide timely and quality care to the disabled veterans for whom it is responsible. Mr. Chairman, we are now seeing that prediction come true.

Without becoming emersed in rhetoric, the fact is the Grace Commission made a sweeping statement about the Federal Government having a profusion of positions in salary grades 11 through 15 as compared to the number of white collar employees in equivalent pay grades in the private sector. Based on this general assertion, the Director of the Office of Personnel Management obtusely issued a memorandum dated January 11, 1984 to the heads of all Federal departments and agencies, subject of which is improved position management of GS/GM 11-15 positions. The essence of the memorandum was that the Federal Government, with 39 percent of its workforce at GS/GM 11-15, has 50 percent more of its employees at high grades than the private sector, and that according to an OPM study, it is estimated that nearly 12 percent of those positions graded 12 through 15 are overgraded. The memorandum went on to describe the initiative chosen by OPM and the Office of Management and Budget, using budget reductions in the amount of $1.6 billion over four years and an estimated $800 million savings each year thereafter as the prime motivator for all agencies to reduce by 2 percent per year for four years the number of positions graded 11 through 15.

Mr. Chairman, anyone who knows anything about personnel management should be acutely aware that such a hypothesis cannot be applied evenly in an operation as vast, as widely dispersed, and as diverse as the Federal Government. Several facts must be stated with respect to the Veterans Administration. By virtue of its organizational structure VA, with over 250 field stations, requires the employment of more program managers in positions such as service chiefs and division chiefs than smaller, less decentralized Federal operations.

Having said that, it must be pointed out that available statistics show that if the Grace Commission's formula is applied to VA, the agency does not have nearly as many personnel in grades 11-15 as the private sector employs in equivalent positions. The Grace Commission has estimated that 26 percent of the white collar employees in the private sector earn salaries equivalent to these Government grades. VA figures reflect that the agency has a 17.5 percent level of GS 11-15 positions - a much lower percentage than the private sector. So one must ask why VA is being forced to reduce the number of middle management positions when its average number of positions in the targeted grades is less than half that of the total Federal Government.

A partial exemption, for title 38 employees, was requested by VA and granted by OMB. However, no mention was made of exempting those positions under title 5. Some examples of title 5 positions that fall within the affected grades are as follows:

Pharmacists
Social Workers
Dietitians
Psychologists
Therapists
Audiologists
Rehabilitation Technicians
Nuclear Medicine Technologists
Radiology Technicians
Inhalation Therapy Technicians
Pulmonary Function Technicians
Voluntary Service Officers

These are certainly not all of the positions under title 5, but they are examples of some of those that provide hands-on care in the medical care facilities.

The American Legion's Field Representatives are hearing horror stories from the management officials at VA medical centers about the difficulties that are being incurred as a result of the reduction initiative. It must be realized that close to 70 percent of all DM&S personnel in the grade 11-15 levels are involved in the provision of direct patient care to veterans. And the remainder are chiefs of service and other management positions. The American Legion is firmly convinced that if the reduction of personnel in these grades is not stopped, the quality and quantity of care provided by VA will be reduced to the point of rendering the VA medical care system totally ineffective.

As stated above, The American Legion is strongly supportive of the proposed amendment of section 210(b) of the title that would provide a mechanism to further protect the Veterans Administration from arbitrary and unwarranted reductions of personnel and positions.

Section 4 of S. 6 would amend section 610(e)(3) of title 38 by extending the eligibility for VA health care of veterans exposed to Agent Orange and ionizing radiation, and who have incurred diseases or disabilities that may result from such exposure, until September 30, 1989.

Public Law 97-72 authorized special eligibility for medical care for veterans exposed to dioxin or other toxic substances contained in defoliants used in Vietnam, or to ionizing radiation, for the treatment of diseases or disabilities, the onset of which cannot be related to any cause other than exposure. The authority is currently scheduled to terminate one year after the Administrator submits the first report to Congress on the Agent Orange study mandated by PL 96-151. The first report is scheduled to be submitted 24 months after the study protocol was approved, which was February 14, 1984. Based on this timetable, the eligibility for health care would expire on February 14, 1987 - over nineteen months prior to the scheduled completion date of the study.

The American Legion urges the enactment of the extension of authority for priority medical care as set forth in this section. Although the tentative date for completion of the Agent Orange study is September 1988, the results will undergo intensive review - a process that is extremely time consuming. In addition, Public Law 98-160 directed the Administrator, in consultation with the Director of the Office of Technology Assessment and others, to determine the feasibility of conducting an epidemiological study of the long-term adverse health effects of radiation exposure. As we understand it, the feasibility study has fallen behind schedule as a result of bureaucratic inertia, and therefore it is impossible to determine if and when an epidemiological study will commence, much less be completed.

These factors make it even more important that veterans at least be entitled to medical care for disabilities and diseases that may result from their exposure to Agent Orange and ionizing radiation while serving on active military duty.

Section 5 of this measure would amend section 620A of title 38 by making permanent the program for the treatment and rehabilitation for alcohol or drug dependence or abuse disabilities, as it is currently a pilot program, established by PL 96-22.

Since the actual efforts to develop meaningful programs for treatment of these disabilities pre-dates PL 96-22, and since it is obvious these disabilities are not going to disappear, we certainly believe such programs should not be conducted by VA on a trial basis. The Department of Medicine and Surgery should know enough about the disabilities by this time to be able to develop effective treatment modalities. As a matter of fact, PL 98-258 directed the Administrator, not later than six months after the date of enactment of the Act (October 19, 1984), to issue guidelines for the treatment and rehabilitation of veterans for alcohol or drug dependence or abuse disabilities. Although the guidelines have not been issued to date, we understand that they are in the process of being developed by DM&S. The American Legion supports the intent of section 5, to make permanent this important substance abuse treatment program.

Section 6 would amend section 618 of title 38 by adding a new subsection stating that notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.

Mr. Chairman, The American Legion strongly endorses the purpose of this section. The Department of Medicine and Surgery has in its rehabilitation procedures a number of programs in the category of incentive therapy or compensated work therapy, in which disabled and hospitalized veterans perform compensated work of a nature that is within the capability of their physical limitations. The work is accomplished under medical management and the programs have proven therapeutic value for the veterans who participate. The programs provide veterans with a measure of dignity and the compensation paid them is below the minimum wage. However, it has been recently determined that the modest remuneration received from such programs is to be counted for pension purposes. This has resulted in a number of overpayments in the cases of veterans receiving nonservice-connected disability pension; and the withdrawal from these worthwhile programs by many veterans because of the requirement to count the minimal amount of compensation as income.

It is The American Legion's belief that this not only defeats the purposes of ongoing medical therapy and rehabilitative processes, but also demonstrates a lack of understanding of the genuine purposes of these programs. Therefore, the Delegates to the 1984 National Convention approved Resolution No. 223, mandating The American Legion to sponsor and support legislation to provide that compensation received from work incentive programs shall not be counted as income for pension purposes. Subsequently, H.R. 1489 was introduced on behalf of The American Legion on March 7, 1985.

Section 7 would amend 38, USC, 3305(b) by including a new paragraph stating that nothing in this section, which pertains to confidentiality of medical quality-assurance records, shall be construed as authorizing or requiring withholding from any person or entity, the disclosure of statistical information regarding VA health care programs, including information on aggregate morbidity and mortality rates associated with specific activities at individual VA health care facilities.

Mr. Chairman, we are in agreement with the intent of this section. The American Legion spoke in favor of the establishment of section 3305 during the legislative process prior to the enactment of PL 96-385. However, our support was specifically based on the need to provide confidentiality of peer review information developed by groups such as the Health Services Review Organization, the Systematic External Review Program, and the Systematic Internal Review Program, all of which are composed of VA health care professionals. We felt at that time, and continue to believe, that unless the remarks and recommendations of the individuals that comprise these groups remain confidential, they would not be entirely uninhibited and straightforward in reporting on deficiencies discovered in the provision of VA health care.

However, we do not feel that the umbrella of confidentiality should encompass statistical information relating to morbidity, mortality, or any other facet of health care to veterans. As consumer advocate for veterans, we feel that these kinds of information should be readily obtainable from VA.

Section 8 of S. 6 would expand section 4110 of the title by adding a new subsection that would limit the power of a disciplinary board to reduce or remove clinical privileges of a VA health care professional. This would be accomplished by requiring that before clinical privileges are reduced or removed, appropriate notice must first be provided to the employee and the board's finding must be based on a finding of a deficiency in the individual's clinical practice.

The American Legion certainly believes that VA health care professionals should be afforded due process with respect to disciplinary actions. However, in reviewing this proposal, we see nothing that would provide protection in instances involving extreme cases of inaptitude, inefficiency or misconduct. Let us say hypothetically that a VA physician is practicing medicine in such a manner that he or she endangers the lives of veteran patients. As we see it, based on the intent of this section, notice would first have to be provided to that individual before clinical privileges could be removed.

We would support this proposal only if a protective mechanism is included to prohibit a situation such as that described above from developing.

Section 9 sets out a proposal for a 48 month pilot program on noninstitutional treatment for the purpose of allowing the Veterans Administration to evaluate the effectiveness, feasibility and desirability of providing eligible veterans who are in need of hospital or nursing home care, or of services to obviate the need for such care, health related services in noninstitutional settings. The proposed pilot program would be carried out in at least five geographic areas, not less than three of which are to involve the use of a geriatric evaluation unit at a VA medical center. Each veteran involved in this program would have a VA case manager responsible for the veteran's access to the appropriate combination of needed services such as medical care and health related services. Examples given are homemaker, personal care, nutrition services and transportation assistance. In order to avoid duplication of services and to evaluate the cost-effectiveness of using services provided by public and private agencies in areas where no VA facility provides them, authority is given to utilize community agencies in not more than two geographic areas for the provision of appropriate health services to the veterans. In turn, the Administrator would be authorized to provide in-kind assistance through the services of VA employees and the sharing of other VA resources to the respective community agencies. The Administrator would be required to submit to Congress a report on the results of the program not later than the thirty-ninth month following its commencement.

Mr. Chairman, The American Legion has over the past several years consistently supported the theory of maintaining the veteran patient in the community as much as, and for as long as possible. In our analysis of the VA report entitled "Caring For the Older Veteran" it is pointed out that in looking to the future from the Legion's standpoint, we will have to realize the fact that many more veterans will be receiving health care in community settings under the Veterans Administration's guidance. Cooperative efforts with community programs are already underway to a limited degree. It is important that these efforts be expanded, and that liaisons with community resources that share VA's interest in the aging are maintained. In addition, our analysis of the report emphasizes that alternative care programs featuring noninstitutional care settings must be aggressively pursued to help contain costs.

More recently, during the March 26, 1985 hearing of this Committee on the issue of VA Construction, we stated that it is our intent to encourage both Congress and VA to foster the development and implementation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients. The trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible. This enhances both the quality of life provided the patient, and is the most cost-effective method of practicing modern medicine.

As for sharing arrangements, there are such arrangements now in place, mainly with VA affiliated university hospitals, and they seem to be working very well. We feel that sharing arrangements should also be pursued with other private sector institutions, as long as they enhance and sustain the primary mission of the VA medical care system with respect to the provision of quality care to sick and disabled veterans. It must be mentioned that the proposed arrangements would have to be closely monitored to ensure that veterans are not haphazardly placed in community settings without adequate oversight by VA.

The implementation of innovative sharing arrangements will expose the VA medical care system to possible attempts of mainstreaming by some private sector health care providers. Thus, it would be extremely important that VA, serving as the primary source of health care, establish and maintain mutually beneficial relationships with community providers. In addition, existing VA programs should be included in such a plan, to the extent possible.

Section 10 of S. 6 would require the Administrator, in conjunction with the Secretaries of Defense and Health and Human Services to submit a report to the Congress advising on how the Federal Government might respond to the needs of individuals who served in the Republic of Vietnam during the Vietnam era as employees of voluntary organizations officially determined to have provided significant assistance to the U.S. Armed Forces in RVN, with respect to health problems that might be related to exposure to Agent Orange or to particularly stressful combat situations. The joint report is to be submitted to the appropriate Committees of Congress within 180 days of enactment. It is to contain various alternative approaches, along with comments on the appropriateness and the advantages and disadvantages of each, and any official recommendations for legislative and administrative action for establishing a program for providing such benefits, services and assistance to these individuals.

The American Legion supports the intent of this provision.

Mr. Chairman, we shall now address S. 876 - legislation titled "Veterans Administration Health Care Programs Improvement Act of 1985."

Section 2 of this bill would establish a five-year pilot program to furnish medical, rehabilitative, and social services as an alternative to skilled nursing home care for veterans who would otherwise require nursing home care. The stated goals of this proposal are to assess the feasibility, medical advantages and cost-effectiveness of providing noninstitutional, community based services instead of nursing home care to certain veterans; and to increase the availability of long-term care options for aging veterans.

The American Legion's support for the implementation of community based alternative care programs as innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of veteran patients, is set forth earlier in this statement in our comment on section 9 of S. 6.

Section 3 of this measure provides for changes in section 620A of the title, specifically the section entitled Treatment and Rehabilitation for Alcohol or Drug Dependence Disabilities. The amendments would change the program from a pilot program to a permanent one, and would build in additional management controls for the purpose of closer VA monitoring of the program.

The American Legion can support the provisions set forth under this section. We believe the VA's work in this area has progressed to the point that it should no longer be carried on as a pilot program, but should be accepted as an effective treatment modality for these forms of disability.

The only problem we envisage with the language included in this section relates to proposed subsection (a)(2)(i), the rate of successful rehabilitation for veterans who have received the contract facilities' care and services under the program, etc. The question may arise as to what constitutes successful rehabilitation in instances of alcohol and/or drug abuse. With both types of abuse there is the ever-present possibility of recidivism. With reference to drug abuse we believe the conduct of a drug free existence is the only mark of success. With respect to alcohol abuse there rises the question of whether the patient can resume "normal" drinking, or should be expected to practice total abstinence. The essential difference between drug and alcohol abuse is that the former is illegal on its face, whereas use of alcohol beverages is legally, morally and socially acceptable, as long as the substance is not abused.

Our present judgment is that effectiveness evaluation will necessitate the establishment of a time limit, beyond which the care providers could not be expected to reach. With respect to drug abuse, we would think that use of drugs during the year following discharge from the program would constitute recidivism. With respect to alcohol use, we believe the only sustainable criterion that could reasonably be used would be evidence of the patient's satisfactory social and economic adjustment, or lack thereof; or the worsening of a systemic illness that could only result from alcohol ingestion, each of these criteria to be monitored for a one year period following discharge from the program.

The fundamental problem is to devise an effectiveness evaluation mechanism that is both realistic and fair as to what can reasonably be expected from the beneficiary of the program, placed against the investment of VA in the rehabilitation of the patient.

Section 4 calls for the establishment of a pilot program of community residential care for chronically mentally ill veterans under section 630 of title 38. Section 630 currently provides that the Administrator may provide assistance by referring a veteran for placement, and aiding such veteran in obtaining placement in a community residential care facility in certain instances. This may be accomplished if the Veterans Administration is furnishing the veteran medical services on an outpatient basis, or furnishing hospital, domiciliary, or nursing home care; or has furnished the veteran such care within the preceding 12 months; and placement of the veteran in a community residential care facility is appropriate. It is important to note that under existing provision of section 630, the Veterans Administration is not responsible for the payment of the charges of a community residential care facility for any care or service provided to a veteran whom the Administrator has referred to the facility under the section.

The provision under consideration would direct VA to establish and conduct the pilot program for veterans suffering from chronic mental illness in five geographic areas, wherein VA would contract for care to be furnished in appropriate community residential care facilities, and pay to each facility the charges for care. The program includes involvement of the availability of VA Psychiatric Day Treatment, and the Hospital Based Home Care Programs.

Under this proposal, eligibility of a veteran is based upon a determination by VA that the veteran is suffering from chronic mental illness and is eligible for VA medical care; that without receiving care furnished by a community residential care facility the veteran would otherwise require hospital care in a VA facility; and that by receiving the care furnished by a community residential care facility and any additional services available to the veteran in his or her community, the veteran eventually will be able to reside at home in a substantially self sufficient manner.

Each VA medical center administering the pilot program is to furnish unified case management services for each veteran involved in the program.

Not later than 18 months after the start of the pilot program, the Administrator would be required to provide to the appropriate Committees of Congress an interim report on the costs and the effectiveness of the program.

Mr. Chairman, the program described in this section would be properly included among those treatment techniques and modalities to which we have referred and offered the support of The American Legion earlier in this statement, in our letter to you dated March 28, 1985, and during the March 26, 1985 hearing of this Committee.

The implementation of this pilot program would allow VA to study the feasibility and effectiveness of outplacing veterans suffering from chronic mental illness who otherwise would be institutionalized as a result of their inability to pay for community based residential care. Additionally, the proposal prudently includes the use of existing VA programs in the formulation of the pilot program, and would only include veterans who wish to participate.

We do feel it important to stress the need for follow-up, as an integral part of the case management, particularly when it is determined that the veteran is able to reside at home. There are already too many people residing in the streets, vulnerable to assault and other criminal acts, and dependent upon the charity of others that have been released from State mental health facilities and other programs with little or no follow-up supervision planned or provided to determine the ability of these individuals to remain self-sufficient.

Section 5 would add a new subchapter to Chapter 73 of title 38, entitled "SUBCHAPTER V - QUALITY ASSURANCE", consisting of new sections 4151 and 4152 relative to responsibilities and reports, respectively.

The proposal directs the Administrator to establish and conduct a comprehensive quality assurance program to monitor and evaluate the quality of health care furnished by DM&S; delineate the responsibilities of the VA Office of Inspector General and the Department of Medicine and Surgery with respect to the monitoring, evaluation and conduct of the VA quality assurance program for DM&S; allocate sufficient resources, including qualified personnel, to the Office of the Inspector General to oversee the quality assurance program for DM&S; and sufficient travel funds to enable DM&S to carry out its quality assurance responsibilities and to enable the IG to monitor the quality assurance program for DM&S.

Additionally, the Administrator is charged with requiring the Chief Medical Director to establish mortality and morbidity rate norms to be used as standards for all surgery programs that are conducted by DM&S; to collect data on mortality and morbidity rates, including, but not limited to, data for each cardiac surgery program and each general surgery program conducted by DM&S; and to compare such data to the established standards, and to evaluate the data to determine whether there are any significant deviations from the standards that would indicate deficiencies in the quality of care. This is to include the level of risks involved, based on the age of the patient, the kind of illness and the severity of the illness.

At the beginning of each fiscal year the VA Inspector General would be required to review the mortality and morbidity data, determine whether the statistics are within the range of the established standards, and submit a report to Congress on the findings.

The American Legion supports the implementation of a quality assurance program, and the delineation of the responsibilities related thereto. We understand that under the ongoing reorganization of MAMOE, the Chief Medical Director has included a new function specifically for the purpose of quality assurance. This legislation would codify the authority and responsibilities of the program and, equally as important, provide for the allocation of resources for the program so as to obviate the need for using patient care funds. As we understand this provision, it would provide the authority for investigating medical care to the Department of Medicine and Surgery, and charge the Office of Inspector General with oversight responsibility. We have no objection with this, or with the requirement that the Inspector General report to Congress annually.

Section 6 of the bill directs the Administrator to establish an Advisory Committee on Veterans Administration Facility Planning, to appoint the members of the Committee from the general public including representatives of veterans. Other members of the Committee are to be, by reason of their education, training and experience, recognized authorities in health care policy and planning, clinical practice and medical facility construction. In addition, representatives of the Departments of Defense, and Health and Human Services are to be members, as well as the Chief Medical Director or his designees.

The Committee is to review veterans' access to the VA health care system; the criteria for sizing VA medical facilities, including an evaluation of the existing VA health care system; an evaluation of VA criteria for sizing medical facilities and the method for determining that criteria; and any recommendations relating to modifications in the criteria and processes.

Not later than October 1 of each year, the Committee is to submit a report consisting of their findings, and any recommendations for administrative and legislative action to the Administrator. Not later than six months after receipt of the report, the

Administrator shall transmit the report together with any comments and recommendations for legislation deemed appropriate to the Committees on Veterans Affairs.

The American Legion must view this proposal with some reservation. First, it assumes that the Administrator would be able to secure experts from the private sector who are impartial. And then it presupposes that the Committee will spend sufficient time to learn and understand the construction needs of the VA medical care system. Before we would support this proposal, assurances would have to be provided that sufficient VA representation is included on the Committee to ensure available expertise on the needs of the system, and that adequate funding is allocated to preclude the use of any patient care funds for the purpose of providing resources for the use of the Committee.

In addition, from our perception the Veterans Administration is, by design or mandate, accumulating an inordinate number of advisory committees. It would be our recommendation that a sunset clause be included in this legislation. A specific amount of time, say for instance two years, may be given for the Facility Planning Advisory Committee to develop a working formula to accomplish the intent of this measure. Once this has been done to the satisfaction of the Veterans Administration and the Congress, the Committee should be dissolved.

The next measure, S. 875, is titled the "Vietnam Veterans' Resource Center Act of 1985." The bill would establish a new Chapter in title 38 as follows: "CHAPTER 40 -- VIETNAM VETERANS'

RESOURCE CENTERS PILOT PROGRAM."

For the purposes of the new Chapter, the term "eligible veteran" means a veteran who is eligible to receive services under section 612A of the title - any veteran who served on active duty during the Vietnam era.

The stated purpose of the program is to increase the overall effectiveness of the services provided under title 38 furnished to Vietnam veterans by increasing the coordination of the provision of these services to those veterans who are eligible.

Under new section 1913, the Administrator is required to establish a pilot program in ten VA readjustment counseling centers (Vet Centers) that are already operating. The services that are to be available and coordinated under the pilot program are readjustment counseling and related mental health services; treatment and rehabilitation of alcohol or drug dependence or disabilities; employment counseling, training and placement services described in section 2003A of the title in cooperation with Department of Labor employees; and outreach and other services authorized to be provided by VA veterans benefits counselors.

New section 1914 states that in carrying out the pilot program, the Administrator is to redesignate each of the Vet Centers selected as a Vietnam Veterans Resource Center; convert the mission of the 10 centers to carry out the pilot program; and transfer the functions and administration of the 10 Vet Centers under section 612A to the Vietnam Veterans Resource Centers.

The staff of each VVRC is to include personnel currently operating the Vet Centers; an employee or employees of the

Department of Veterans Benefits experienced in career development and vocational rehabilitation and counseling; one or more veterans benefits counselors; and VA employee or employees qualified in alcohol and drug counseling, treatment and rehabilitation.

The Director of a VVRC would be authorized, in consultation with a VAMC or VARO Director, to assign a VVRC staff member to work part time in a VA medical center or regional office, scheduling the work time of the member in each facility as needed. The primary responsibility of such an individual would be to furnish services to eligible veterans in the VVRC under the pilot program.

The Team Leader of each of the 10 Vet Centers included in the pilot would be redesignated as Director of the VVRC. In the case of a Director who terminates employment, transfers to another position, or otherwise becomes unavailable to serve as Director, a qualified member of the professional staff of the VVRC is to be designated as Director.

A Vietnam Veterans Resource Center is to furnish unified case management for each veteran who resides within the geographic area and requests or receives services, including services furnished under contract. Case management includes the provision and coordination of services, referral for services, and follow-up functions. In furnishing unified case management the VVRC staff is to cooperate with Disabled Veterans' Outreach Program specialists. Authorization would be provided for the assignment of DVOPs to the VVRCs, as needed to carry out the pilot program.

Under new section 1915 the Deputy Administrator would be charged with administration of the pilot program. At least one representative of DM&S and one representative of DVB would be detailed to the Office of the Deputy Administrator to assist in the administration of the program. In addition the Deputy Administrator is to consult with the Director of the Readjustment Counseling Service, taking into consideration the goals and objectives of carrying out the Readjustment Counseling Program set forth in section 612A of the title.

New section 1916 requires that not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans Affairs a report on the pilot program, including findings on the effectiveness of coordinating the provision of services; the cost effectiveness of the program; a description of any administrative actions the Administrator would plan to take to increase the scope of the program; any legislative recommendations; and a comparison of such findings, plans, and recommendations with the evaluation of and the recommendations relating to the Readjustment Counseling Program that is required by section 612A of the title to be submitted to Congress not later than April 1, 1987.

Section 1917, as contained in S. 875, directs the Administrator to promulgate regulations considered appropriate to carry out the pilot program. The pilot program would terminate three years after the date the program is established, which, under this provision, would be 90 days following enactment.

Mr. Chairman, the readjustment of Vietnam veterans is a priority issue of The American Legion. We continue to find that the Vet Center program is doing well in accomplishing the purpose for which it was established - to provide readjustment counseling and referral services to those veterans who have not entirely completed post-Vietnam recovery and readjustment processes.

American Legion Field Representatives visit the Vet Centers during site visits to VA medical centers throughout the country, and their reports are complimentary of the program, and contain positive comments in a vast majority of instances.

The American Legion would not object to the implementation of a pilot program of Vietnam Veterans Resource Centers in 10 existing Vet Centers. However, our knowledge, based upon the findings of our Field Representatives during their visits to Vet Centers bring cause for us to wonder if the adding of new service delivery obligations will not overtax the crowded conditions that already exist in many of the facilities.

It is difficult to conceive a group counseling session and alcohol and/or drug counseling being carried out simultaneously, while at the same time a veterans benefits counselor is attempting to provide assistance to a veteran in the development of a claim. Based on our experience, consideration must be given to space limitations that would prohibit the concurrent provision of multi-faceted services such as those described in most existing Vet Centers.

Amendment No. 22 to S. 6 - provides a technical amendment to conform subsection (g)(1)(B) of section 612A of title 38, relating to the continuing availability of readjustment counseling services for Vietnam era veterans, to the amendment of subsection (a) of section 612A made by section 101(a) of the Veterans Health Care Amendments of 1983.

The American Legion is supportive of this amendment.

Mr. Chairman, the next legislative initiative that we shall address is in the form of a discussion paper titled "VA Medical Care Policy", and subtitled "Six Key Ingredients to Comprehensive Reform of VA Medical Care Eligibility." In essence, this paper contains proposals relating to a means test for nonservice-connected disabled veterans, regardless of age; and the implementation of third party reimbursement for the cost of VA medical care and treatment to veterans with nonservice-connected disabilities.

Item 1 of the paper calls for the repeal of section 610(a)(6) of title 38, which would eliminate the authority to provide nonservice-connected veterans age 65 and older with eligibility for VA hospital and nursing home care without regard to their inability to defray the expense of such care.

The second item states that the following veterans will continue existing eligibility within the limits of VA facilities based on medical determination of need: service-connected veterans for service-connected disabilities; service-connected veterans for nonservice-connected conditions; veterans who were prisoners of war; veterans exposed to ionizing radiation during service; Vietnam veterans exposed to Agent Orange and other herbicides; VA pensioners; and World War I, Spanish American War, and Mexican Border Period veterans.

Item 3 is to clarify and define eligibility for other nonservice-connected veterans based on inability to defray necessary hospital and nursing home expenses.

It would amend section 622 of title 38 to add language identifying that if nonservice-connected veterans, other than those with continuing eligibility, are able to demonstrate, with verifiable evidence, that gross annual family incomes including assets, as defined in the improved pension program, are below double the maximum annual VA pension rate based on family size, they are deemed to be unable to defray necessary medical expenses. As defined in the pension program, out-of-pocket medical expenses for other family members would reduce the gross family income for determining eligibility.

Item 3 goes on to state the following:

"For NSC veterans whose gross annual family incomes including assets are in excess of double the maximum annual VA pension rate, procedures would be established by regulation identifying the conditions under which veterans may be considered unable to defray further expenses and VA care could be provided for a particular medical service.

" -- Except for veterans requiring emergency care and care in certain extraordinary circumstances, such veterans would not be eligible for VA health care until the veteran's out-of-pocket medical expenses exceed certain levels. These medical expense levels, are termed the 'expected medical expense contribution.'

" -- The expected medical expense contribution would form the basis of a means test procedure to evaluate the veteran's inability to defray further medical costs. The following schedular display would be used.

Income Interval as a Percent of Double the Pension Maximum Annual Rate	Expected Medical Expense Contribution as a Percent of Income in Excess of Double the Pension Maximum Annual Rate
100% - 116.7%	25%
116.8% - 133.3%	35%
133.4% - 200.0%	50%
200.1% - 566.7%	75%
566.8% and over	90%

" -- If the veteran presented reasonable evidence that out-of-pocket payments for his/her care to private providers and third parties during the preceding twelve months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The precise evidence acceptable to VA and pertinent to such claims would be defined in regulations.

" -- Veterans requiring emergency care and care in certain extraordinary circumstances could be admitted for VA care, but would be billed for the cost of such care up to their expected medical expense contribution. These terms would be further defined in regulation. In addition, the veteran would be billed up to his expected medical expense contribution for any examination provided to determine if emergency care is required.

" -- Amend title 38 to provide that the Administrator shall issue rules on how veterans statements of income and prior medical expenses shall be verified.

" -- For treatment of these NSC veterans, if the veteran is covered by a private insurance plan, the private plan would be required to reimburse the VA for medical expenses incurred by the patient that are covered by the plan. The VA would bill the veteran the difference between the insurance company payments and actual VA costs, but not in excess of the veteran's expected medical expense contribution."

Item 4 explains waiver authority by stating that in exceptional, unusual, and rare circumstances, the Administrator could waive the veterans expected medical expense contribution.

The Administrator would have authority to grant waivers for a portion or all of an individual veteran's medical expense contribution limited to the period of the episode of care for which the veteran claimed relief. Such waivers would only be considered upon application of the individual veteran, and a demonstration by the veteran that the contribution would effect an unusual and exceptional hardship on the veteran. Such waivers will not be granted categorically, either for categories of illness, expenses, incomes, procedures, or veterans. The Administrator would issue regulations setting forth the procedures for granting such waivers. The Administrator's decision to grant or not to grant a waiver would not be subject to Judicial review.

Mr. Chairman, as we recently informed the Committee during its hearing on the FY 1986 Veterans Administration Budget, The American Legion is opposed to the implementation of a means test for nonservice-connected veterans regardless of their age. We believe a means test would prove to be ineffective because available information indicates that most of the nonservice-connected veterans that use the VA medical care system are old, sick and poor. If forced out of the VA system these veterans would have to resort to Medicare, Medicaid, or to other publicly supported institutions.

One of the primary reasons for the implementation of subsection 610(a)(6) of the title was the fact that nearly every veteran age 65 and up is eligible for Medicare. The legislative history of PL 91-500 shows that at the time the legislation was being considered, the cost of the provision of treatment under Medicare was higher than the cost of care by VA. It was estimated that savings to the Federal Government would exceed $8 million during FY 1971 because veterans were treated by VA and not under Medicare.

Current available figures reflect that the average daily cost of treatment in a VA facility is still less than the average daily cost of care provided through Medicare. Thus we are mystified as to how the repeal of section 610(a)(6) is supposed to save the Federal Government money, when in fact, the provision of medical care costs more under Medicare, which is expected to cost over $70 billion this year.

The implication that the VA system is crowded with affluent veterans is a myth. The American Legion earnestly suggests that before any consideration is given to this proposal, the Committee should require from VA an updated profile of the current patient population of the VA system. If, as we believe, such a profile demonstrates that the veterans using the system are overwhelmingly old and poor, then the question has to be answered, why establish another administrative mechanism that will accomplish nothing.

Item 5 addresses legislation to require reimbursement from a veteran's private health insurance plan. It states that legislation would be drafted to prohibit exclusionary clauses in

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insurance contracts, effective at the first renewal of such contracts.

Except for service-connected veterans, VA would examine the family health insurance coverage status of each veteran to whom VA provides care. For veterans so covered, VA would collect insurance proceeds by assignment to the extent such proceeds reimburse VA its actual costs of care.

The American Legion is mandated to oppose third party reimbursement for cost of medical care and treatment to veterans with nonservice-connected disabilities. The primary point of our opposition is that in essence, veterans would be paying for their VA medical care through health insurance premiums. If third party reimbursement were implemented the VA health care program would be changed in its essential nature from a benefit to a cost-sharing medical plan.

The projected savings expected to be gained from third party reimbursement is $65 million, and quite frankly, we fail to see how that could be an accurate figure. We have heard statements made in the past by VA officials during Congressional hearings to the effect that the administrative costs necessary to implement the mechanism for collection of insurance payments would probably exceed the costs that are recovered. Such reasoning seems logical when considering the majority of nonservice-connected veterans using the VA system are probably not covered by insurance, and that complicated problems involving cost formulas, quality controls and distribution of services would have to be resolved before third party reimbursement legislation could be implemented.

It is understood that there is some sentiment in the Congress and the Administration that the present system provides a free ride for insurance companies when veterans with insurance use the VA medical care system; and that third party reimbursement would have minimal effects on insurance premiums. We have knowledge that the Insurance Industry is prepared to challenge the veracity of these statements, and that if third party reimbursement legislation were enacted, they will undoubtedly challenge the constitutionality of such a law, thus rendering it ineffective for a lengthy period of time.

Finally Mr. Chairman, we fail to understand how the Department of Medicine and Surgery could possibly find the personnel needed to administer a complicated third party reimbursement program, while at the same time the Department is being forced to eliminate positions and FTEE to the point that the situation is now beginning to effect the ability of VA to provide quality health care to veterans.

S. 1007 - the "Veterans Health Care Promotion Act of 1985", would, in part, amend section 5002 of title 38 to direct the Administrator to develop and carry out a pilot program to determine the most cost-effective methods of acquiring medical facilities to meet the needs of the Veterans Administration and otherwise to promote additional health care for eligible veterans. A summary of the provisions of the proposal follows:

The bill would require that the Veterans Administration's first option when developing plans for new or replacement medical facilities shall be to consider leasing or purchasing existing community facilities.

It sets up a pilot program for the purpose of studying four different scenarios. The first of the four would be the use of privately built, privately operated nursing homes that VA would contract eligible veterans to in a 5 year agreement.

The second model would be a privately planned, designed and built nursing home that would be leased to and operated by VA. This nursing home would revert to the private sector when no longer needed by VA.

The third would require VA to purchase an existing facility. And the fourth option would be for VA to lease an existing facility.

In addition, the bill would require VA to report to Congress on the potential cost savings of increasing the number of nursing home beds contracted to community nursing homes; and it recommends that VA increase the share of nursing beds in the community to 60 or 75 percent.

Mr. Chairman, we will defer our response to this proposal until it is considered by the National Veterans Affairs and Rehabilitation Commission during its meeting today in Indianapolis, Indiana. Following the subsequent meeting of our National Executive Committee, we will communicate with the Committee staff.

The final draft proposal under consideration would amend title 38 to require the Administrator to carry out not less than 5 demonstration projects to furnish chiropractic services to certain veterans and to evaluate the cost effectiveness of furnishing such services.

In developing the demonstration projects, the Administrator would be directed to consult with the Secretary of Defense regarding the demonstration projects carried out pursuant to section 632(b) of the Department of Defense Authorization Act of 1985.

The measure contains provisions relating to the establishment of cooperative agreements between VA and not less than 5 chiropractic colleges in 5 geographic regions of the United States; the promulgation of regulations under which VA would provide reimbursement for chiropractic services, including annual limits of $600 for any one veteran and $2 million for the entire demonstration project; and a requirement that the Administrator prepare and submit a report to the Committees on Veterans Affairs not later than December 31 of each of the years 1986, 1987 and 1988, on the numbers of veterans involved in and the cost of the project.

The American Legion's policy on establishing chiropractic as a health care alternative to veterans was formed as a result of a study conducted by a Subcommittee on Chiropractic of our Veterans Affairs and Rehabilitation Commission. The Subcommittee inquired into the question of whether veterans should have greater access to chiropractic through programs administered by VA. The Subcommittee concluded that legislation to statutorily strengthen veterans access to chiropractic in seeking care from VA to which they are already legally entitled is not presently required, and it was recommended that The American Legion should neither sponsor nor support such legislation. Therefore, we are not in support of this measure.

Mr. Chairman, that concludes our statement.

Mr. PRINCIPI. Mr. Schwab.

Mr. SCHWAB. Thank you, Mr. Chairman. It's a privilege to be here and present the views of the Veterans of Foreign Wars of the United States.

We have under consideration five bills with some 17 provisions and I'll just cover them briefly since they are covered more extensively in my prepared text.

S. 875, The Vietnam Veterans' Resource Center Act of 1985. The VFW supports the concept of the program. We have several suggestions with respect to it, and I'm sure you've read my testimony and you know what they are.

S. 876, The Veterans' Administration Health-Care Program Improvement Act of 1985. One of the major provisions would establish a 2-year pilot program in five geographic areas to provide medical rehabilitative and social services to eligible veterans as an alternative to nursing home care.

The intent of this bill is certainly supported by the VFW. It is a pilot program, and in reality an enhancement of another pilot program, the Adult Day Health Care Program, authorized by Public Law 98-160, which we previously supported.

The intent of both of these programs obviate the need for nursing home care and we fail to appreciate how one can accomplish the purpose independent of the other. Inseparable from either pilot program, we believe, is the Geriatic Research, Education and Clinical Centers Program authorized by Public Law 96-330 for which appropriations were authorized through the fiscal year 1985 and subsequent fiscal years by Public Law 98-258.

However, there's been no funding proposed for the 1986 budget.

One provision, the bill would require the VA to establish and conduct a comprehensive quality assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery. We don't support this provision to the bill. We think it's degrading. It's the evaluator being evaluated again. The Big Brother approach, and if you persist in advancing this provision it is recommended that physicians be on the staffs and that adequate travel funds be appropriated.

The final provision of this bill would establish an advisory committee on Veterans' Administration facility planning. We have no problem with this. We'd be happy to assist in that matter if called upon to do so.

The next bill is S. 6 introduced by the ranking minority member of this committee—would expand the dates for the Vietnam-era, which we fully support. One provision dear to our heart in this bill is the work therapy program, the work incentive program of the VA, and we have a resolution supporting—excluding work therapy program stipends as countable income for the pension program.

This program in making buddy poppies has been in effect since World War I. The disincentive of reducing pension has reduced the number of veterans working in these programs, and we don't think the program should be further hobbled by offsetting their modest remuneration from pension payments.

Mr. Chairman, the bill introduced by Senator Denton and Senator Boschwitz, S. 1007, would require the VA in a stipulated period of time to buy and lease facilities for the VA. We oppose the advancement of this bill. The VA has authority now to purchase—or to lease other facilities. We don't think they should be put under time constraints, but let them go and find them as they will and where they are needed.

And, the bill introduced by Senator Thurmond, S. 1052, would require a demonstration product in chiropractic care and we would prefer to defer action on this bill and wait and see the outcome of the Department of Defense demonstration programs, since it is estimated that the cost would be as much as $7 million and we are operating under severe budgetary constraints, and I thank you.

Mr. PRINCIPI. Mr. Schwab, before proceeding to Mr. Gorman, may I just ask you a question regarding S. 1007, the bill introduced by Senators Boschwitz and Denton.

Do you believe the VA should be encouraged to purchase or lease existing facilities before they expend dollars on new construction as an alternative to keeping the cost down?

Mr. SCHWAB. I think they should be encouraged to purchase or lease any facility that is in the proper location and meets the criteria of privacy and safety standards, yes.

Mr. PRINCIPI. Thank you, sir.

[The prepared statement of Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States, follows:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

PREPARED STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than two million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, S. 875 introduced for you by the majority leader of the Senate, the Honorable Robert Dole, is identified as the "Vietnam Veterans' Resource Center Act of 1985."

Briefly, your bill would establish a pilot program of three years duration wherein ten of the existing Vet Centers established under the provisions of section 103 of Public Law 96-22 to provide readjustment counseling to Vietnam-era veterans would be upgraded and redesignated as Vietnam Veterans' Resource Centers (VVRCs). These facilities would be removed from the jurisdiction of the Department of Medicine and Surgery and placed within the purview of the Deputy Administrator of Veterans Affairs with representatives from both the Department of Medicine and Surgery and the Department of Veterans Benefits who would jointly administer the program. Eligible veterans would be provided readjustment counseling and related health services, treatment and rehabilitation for alcohol or drug abuse or dependence, employment counseling, training and placement services and such outreach and other services authorized to be provided by veteran's benefits counselors. The Vet Center program and the Pilot VVRC Program will expire with the fiscal year 1988 with services previously provided by Vet Centers then continuing to be available within the Veterans Administration Medical Centers.

Mr. Chairman, the VFW supports the concept of your bill. Notwithstanding, we believe the legislation must be amended and the record clarify areas of concern which we believe have not been adequately addressed.

When members of our staff sat to critique S. 875, we agreed without exception, that the proposed centers be not identified as Vietnam Veterans' Resource Centers but, rather, Veterans' Resource Centers. The Vietnam war ended more than a decade ago and for some veterans nearly a quarter of a century has passed since their involvement. Therefore, we should not be a party to differentiating between veterans of various conflicts with continuing problems but encourage any veteran with wartime service to take advantage of the Veterans' Resource Centers if the need exists. This, of course, would require changing the definition of an "eligible veteran" to that enunciated in 38 USC 101(12).

Mr. Chairman, your bill makes no provision for any funding for the centers to be upgraded. Obviously, when the mission of any activity is expanded, it must be anticipated that the physical plant in which housed may have to be improved, additional equipment may well be required and the increased record keeping will almost surely demand more clerical help.

Another area of concern is the rather cavalier manner in which the professional staffing requirement for the centers is addressed. In the CONGRESSIONAL RECORD of April 3, 1985, you stated in part: "In the 10 VVRCs, the staff would furnish unified case management to eligible veterans. What this really means is that a veteran who walks in the door will be seen by someone who is qualified to determine his or her needs and would designate the appropriate employees and services within the VVRC...Under my proposal, a designated case manager would be assigned to the veteran when he or she walks in the door to improve coordination of services."

Most of the benefits proposed in this bill are already available through various sources within the Veterans Administration under the provisions of 38 USC 612(a) or the Department of Labor and, in the case of the Disabled Veterans' Outreach Program (DVOP), representatives are outplaced to over 100 Vet Centers as enunciated in 38 USC 203(A)(B)(2).

"Unified case management" is a nice phrase, Mr. Chairman, but it also implies and bespeaks of highly personalized services demanding at some point considerable time of professional personnel. Whatever time professional health-care personnel spend away from the Veterans Administration Medical Centers merely exacerbates the personnel and funding shortage now causing the denial of medical care to a quarter of a million veterans a year. Due to the severe personnel reductions within the Department of Veterans Benefits, any time spent away from the Regional Office will not enhance that operation. The outplacement of a Veterans Benefits Counselor would create a demoralizing affect on staff personnel who will be given additional administrative burdens and as a result of split loyality, promote confusion and frustration among the staff.

However, the greatest disappointment in the bill is where it states that the Administrator may request and the Secretary of Labor may assign Disabled Veterans' Outreach Program Specialists to the centers. We find this permissive authority unacceptable and urge that the word "shall" be substituted for "may" as appropriate, with the caveat that such outplacement to a resource center be done only when the demographics and workload require a representative of the DVOP.

The professional in the area of employment will be required to provide case management, testing, evaluation, identification and conduct any training program. It is, therefore, the Local Veterans Employment Representatives (LVERs) who would, in most cases, be the better trained and capable individual to be utilized for this purpose rather than the DVOP representative. According to the Vietnam Veterans' Readjustment Counseling Program, forty percent to fifty percent of Vet Center users are those veterans with job related problems. While these resource centers would, ostensibly, be an altogether different and separate program from the Readjustment Counseling Centers, it would appear that professional courtesy and the need to coordinate with the overall Readjustment Counseling Program would require that direct contact with the Director of the Readjustment Counseling Service not be bypassed in the reporting chain to the Deputy Administrator of Veterans Affairs.

While it may seem far-fetched, we must not lose sight of the rationale for such resource centers to be worked into a clearinghouse or initial contact point for referrals to consolidate Veterans Administration Regional Offices should this ever take place. In addition, these centers may very well be a duplication of the effort now being carried out in regional offices. Thus, it may very well serve a better purpose to place some or all of these Veterans Resource Centers in either a Regional Office or a VA Medical Center.

S. 876, again, introduced by the Majority Leader for you, Mr. Chairman, is cited as the "Veterans' Administration Health-Care Programs Improvement Act of 1985."

Section 2 of the bill would amend 38 USC 620 by establishing a two-year Pilot Program in five geographic areas to provide medical, rehabilitative, and social services to eligible veterans as an alternative to nursing home care. Such care would be provided by contract with non-Veterans Administration public or private providers. If neither option is feasible, the Veterans Administration would develop health related and supportive services to obviate the need for nursing home care provided by the Veterans Administration.

Mr. Chairman, the intent of the above is supported by the VFW when more sophisticated care is not required so long as it is understood that the Veterans Administration is the first recourse for health care for veterans. However, we do harbor several concerns.

Although the bill stipulates that the cost of the pilot program in any fiscal year may not exceed sixty percent of the cost of nursing home care, we are unable to identify a provision providing the necessary funding. We simply do not need a program to be funded by siphoning money from another health-care endeavor.

Mr. Chairman, this pilot program is in reality an enhancement of another pilot program--the Adult Day Health-Care Program--authorized by Public Law 98-160 which was supported in testimony by the VFW. The intent of both programs is to obviate the need for nursing home care and we fail to appreciate how one can accomplish its purpose independently of the other. Inseparable from either pilot program is the Geriatric Research, Education and Clinical Centers (GRECC) Program authorized to be expanded by Public Law 96-330 and for which appropriations were authorized through the fiscal year 1985 and subsequent fiscal years by Public Law 98-258. As you must be aware, no GRECC funding appears in the President's proposed budget. Obviously, some provision must be made for continuing coordination between these programs if any are to realize their full potential.

Mr. Chairman, section 3 of the bill would make permanent the pilot program of halfway houses for those veterans with alcohol or drug dependence disabilities. The authority for which is due to expire with the current fiscal year.

It is the opinion of our VFW Medical Consultant, Dr. Turner Camp, that this should not become a permanent program but, rather, should have a definite sunset date. The reasoning being that a date certain for termination inculcates the stimulus and incentive to develop techniques which would eliminate the continuing need for halfway houses. Therefore, we recommend a three-year extension of the program.

A three-year pilot program commencing January 1, 1986, would be authorized by section 4 of the bill to provide community care for chronically ill-mental patients in five geographical areas.

Mr. Chairman, this program would in many cases obviate the need for hospital or nursing home care and, hopefully, result in veterans becoming able to reside at home in a family setting. The VFW supports this provision. However, since there already exists within the Veterans Administration a "Community Residential Care" program of longstanding, this program for mental patients should be otherwise designated to avoid confusion.

Mr. Chairman, section 5 would require the Administrator of Veterans Affairs to establish and conduct a Comprehensive Quality Assurance Program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery (DM&S) to eligible veterans. In addition, there is the requirement to delineate responsibilities of the Inspector General (IG) and the Department of Medicine and Surgery to monitor, evaluate and conduct the program for DM&S and to allocate resources to the IG and DM&S for the purposes of:

1. establishing mortality and morbidity standards for all surgery programs;
2. collecting and analyzing data on the patient population, the level of risk involved in surgery based on age, illness and such other factors considered appropriate;
3. comparing data to standards for the purpose of identifying deficiencies in the quality of care; and

4. making any recommendations based on the comparisons made above.

Mr. Chairman, the VFW views the foregoing as a redundant and degrading exercise of evaluating the evaluator. Appropriate authority is already held by both the Inspector General and the Medical Inspector. To further pursue this ill-conceived "big brother" is watching plan could well destroy morale completely and make it difficult in the extreme to recruit and retain quality professional health-care personnel. However, if for some reason this Committee sees fit to persist in this matter, it is recommended physicians be on the staffs and adequate travel funds be appropriated.

The final provision of the bill, Mr. Chairman, would establish an Advisory Committee on Veterans Administration Facility Planning. The committee would be appointed by the Administrator to include:

1. representatives of veterans;
2. recognized authorities in fields pertinent to health-care policy and planning, clinical practice, and medical facility construction; and
3. as ex-officio members
    a. the Secretary of Defense or his designee;
    b. the Secretary of Health and Human Services or her designee; and
    c. the Chief Medical Director or his designees.

The committee would review the criteria for sizing Veterans Administration Medical facilities to include:

1. an evaluation of veterans access to the health-care system;
2. an evaluation of sizing criteria and the method for determining such; and
3. any recommendations relating to modifications in the criteria and process.

Mr. Chairman, if such an advisory committee is, indeed necessary, in our opinion, the Chief Medical Director or the Deputy Chief Medical Director should sit as a member of the committee rather than as an ex-officio member. Furthermore, we see no valid reason for including as an ex-officio member the Secretary of Health and Human Services since that department is not constructing medical facilities. The VFW would welcome the opportunity to assist the Committee with its review.

Mr. Chairman, the next bill under consideration is S. 6 introduced by the Minority Leader of the Senate, the Honorable Robert C. Byrd, for the Ranking Minority Member of this Committee, the Honorable Alan Cranston, and may be cited as the "Veterans' Administration Health-Care Amendments of 1985."

Section 2 of this bill would amend 38 USC 101(29) by expanding the dates of the Vietnam Era from August 5, 1964 - May 7, 1975 to February 21, 1961 - May 7, 1975. The rationale for this proposed change is that February 28, 1961 is the date selected by the Department of the Army for the award of the Combat Infantryman's Badge and the Combat Medic Badge.

Mr. Chairman, this provision fulfills in part our current VFW resolution, No. 635, entitled "Change of Dates for Entitlement under the Provisions of U.S. Code, Title 38, Subsection 101, (29) for Vietnam Era." However, our resolution calls for recognition of the Vietnam Era commencing July 1, 1958--the date established for award of both the Armed Forces Expeditionary Medal and the Navy and Marine Corps Expeditionary Medal.

Section 3 of the proposed legislation would prohibit the Administrator of Veterans Affairs, in any fiscal year, to implement a systematic reduction of any specific grade for the purpose of reducing salary costs unless the Administrator first submits to the Veterans' Affairs Committees of both Houses of Congress a detailed report of justification at least ninety days before implementation. In addition, and within forty-five days of the Administrator's report, the Comptroller

General of the United States shall submit a report to the Veterans' Affairs Committees expressing an "opinion as to the accuracy of the Administrator's determination."

Mr. Chairman, the alacrity with which the Administration moved to implement the highly controversial recommendation of the President's Private Sector Survey on Cost Control (referred to as the Grace Commission) with respect to Federal civilian employees in grades GS-11 through GS-15 makes abundantly clear the need for this provision.

You will recall, Mr. Chairman, that the Grace Commission alleged that the Federal Government employs thirty-nine percent in the GS-11 through GS-15 level whereas in the private sector only twenty-six percent of white-collar employees fall within that salary level. However, the Veterans Administration has but 16.9 percent of such middle management personnel. Recognizing to some extent the very unique nature of the Veterans Administration and its health-care personnel requirements, the Administration exempted for the current fiscal year the mandatory reduction of physicians, nurses and other health-care professionals employed by the Department of Medicine and Surgery under the provisions of Title 38 of the United States Code. Unfortunately, Veterans Administration personnel employed under the provisions of Title 5 of the United States Code were not extended the same consideration and the two percent reduction in funding must still be absorbed by the Veterans Administration.

Mr. Chairman, under the provisions of section 4, health-care eligibility for veterans suffering from both radiation and herbicide exposure would be extended beyond the present sunset date of February 14, 1987 until September 30, 1989. Since it appears all studies may not be sufficiently complete by 1987 to allow final determinations, the VFW supports such extension.

The pilot program of halfway houses for veterans suffering from alcohol or drug dependence due to expire September 30, 1985, would be extended three years by section 5 of S. 6. The VFW supports this extension for the reason stipulated earlier with respect to one of the provisions of S. 876.

Mr. Chairman, the small stipend paid to veterans for compensated work therapy or incentive therapy would not be counted as income for pencion purposes under the provisions of section 5 and is supported in the strongest terms by our current VFW resolution, No. 607, entitled "Incentive Therapy Program," a copy of which is appended to my testimony.

Hundreds of long-term disabled veterans within Veterans Administration and State Veterans Homes have worked year-round on such work therapy programs as assembling VFW Buddy Poppies, tying them in bunches of tens and packing them in boxes of 500s or 1,000s for shipment. However, 38 USC 503(a) stipulates that all income from any source not specifically excluded by law must be counted as income for pension purposes thus reducing pension payments. As a result, current law is a disincentive for these disabled veterans to participate in work therapy programs and participation in important rehabilitative activities is diminishing. This Buddy Poppy program, which has been in existence since World War I and which has raised millions of dollars each year for the benefit of disabled veterans, along with other work therapy programs, should no longer be hobbled by offsetting the very modest remuneration from pension payments.

Mr. Chairman, 38 USC 3305 enunciates the confidentiality of medical quality-assurance records and documents created by the Veterans Administration. Section 7 of the instant legislation would amend 38 USC 3305(b) to provide that "Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Veterans' Administration health-care programs (including information on aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities)." The VFW would be more comfortable with

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the proposed amendment if following the words "any person or entity" was added a comma and the verbage "normally authorized access or have a legitimate need for such information."

Section 8 would amend 38 USC 4110, which addresses Disciplinary Boards within the Veterans Administration's Department of Medicine and Surgery, by including therein cases involving proposed reductions or revocations of the clinical privileges of health-care personnel.

Although this proposal would give statutory authority to do what many have already been doing, we are not certain a Disciplinary Board is the appropriate forum vis-a-vis the local medical center director.

A four-year pilot program or noninstitutional treatment in Veterans Administration and appropriate public and private agencies to obviate the need for hospital or nursing home care would be established by section 9. The pilot program would function in not less than five geographic areas and in not less than three areas involving the use of a geriatric evaluation unit at a Veterans Administration health-care facility. Health related services would include, but not be limited to, homemaker, personal care, communal or at-home nutrition, and transportation assistance services.

Mr. Chairman, this proposed pilot program to obviate the need for institutional care is also an enhancement of the Adult Day Health-Care Program. We believe that all of the proposed pilot programs should be conducted within medical centers having a geriatric evaluation unit. Also, we oppose the Administrator providing "in-kind assistance" and "sharing resources" to an entity furnishing services other than to the extent health-care services are provided a non-veteran in an emergency or as a humanitarian act.

The final section of this omnibus bill would direct the Administrator of Veterans Affairs and the Secretaries of Defense and Health and Human Services to submit to Congress a joint report on the question of the U.S. Government's responsibility for disabilities that possibly resulted from service in Vietnam to civilians who were employees of voluntary organizations which provided significant assistance to the United States Armed Forces such as the American Red Cross and USO.

Mr. Chairman, this is not a veteran's issue. The Administrator of Veterans Affairs should not be made a party to such an effort and we oppose enactment of this provision.

The Honorable Jeremiah Denton has recently introduced for himself and the Honorable Rudy Boschwitz S. 1007, the "Veterans' Health-Care Promotion Act of 1985." The bill requires the Administrator of Veterans Affairs to expeditiously pursue a pilot program to ascertain the most cost-effective methods of acquiring medical facilities. In compliance therewith, the Administrator of Veterans Affairs shall:

1. Give first consideration to leasing or purchasing any existing community medical facilities;
2. Not later than January 1, 1987, enter into contracts to:
    a. authorize an appropriate entity to construct and operate a nursing home for the Veterans Administration which would be funded by the Veterans Administration and under a contract of at least 5 years, refer sufficient veterans who require nursing home care to assure an 80% occupancy rate. Rights, title and interest in the nursing home would vest in the United States;
    b. authorize an appropriate entity to design and construct a medical facility to be leased by or sold to the Veterans Administration; and
3. Acquire two existing medical facilities by:
    a. purchasing in an urban area one which furnishes both hospital and nursing care, and
    b. leasing a medical facility in an urban area.

In addition, and not later than ninety days following enactment of the bill, the

Administrator of Veterans Affairs shall:

1. Submit reports to the Senate and House Veterans' Affairs Committees with respect to:
   a. the extent to which the Veterans Administration furnishes respite care to elderly and disabled veterans and plans for such future care, and
   b. a cost estimate of increasing by 50% and, also, 75% the number of community based nursing home beds available to veterans.

Other provisions of the bill, Mr. Chairman, would encourage the Administrator of Veterans Affairs to contract out in other than urban areas as many eligible veterans as practicable in nursing homes located in the veterans community and require cost savings and the reallocation of resources.

Mr. Chairman, while we would encourage the Administrator of Veterans Affairs to exercise the authority he now has to acquire by purchase or lease existing medical facilities, it would, in our opinion, be the hight of imprudence to require him to do both within a stipulated period as in the instant legislation.

The criteria for acquisition of any medical facility must first be that it is located where the most pressing and clear cut need exists and, then, the cost effectiveness factor keeping in mind that our veterans are, indeed, entitled to modern facilities with the most sophisticated equipment. In addition, the option of acquiring existing facilities must be approached with great caution so that neither the Veterans Administration nor the Federal Government can ever be subjected to criticism or suspected of chicanery in bailing out a failing hospital overbuilt and over bedded for private gain or otherwise assuming someone's unwanted white elephant.

Mr. Chairman, the report required of the Veterans Administration with respect to respite care for elderly and disabled veterans is innocuous enough. However, a much better approach in our opinion is H.R. 505 which would authorize respite care for veterans suffering from terminal illnesses and, also, allow the transfer of veterans at VA expense directly from a VA nursing home or domiciliary to a community facility without first having to be discharged from a VA hospital. The appropriate subcommittee of the House Veterans' Affairs Committee held a hearing with respect to H.R. 505 on April 25, 1985.

The report required with respect to the cost of greatly increasing the number of contract nursing home beds we view with concern since we would oppose escalating the contracting out of such care to a level which could lead to mainstreaming.

Obviously, Mr. Chairman, the VFW opposes the advancement of S. 1007.

Mr. Chairman, the draft bill of the Honorable Strom Thurmond is cited as the "Veterans' Chiropractic Services Demonstration Projects Act of 1985." Under the provisions thereof, the Administrator of Veterans Affairs is required to:

1. Conduct at least five demonstration projects in as many geographic regions of the country during the next three fiscal years.
2. Consult with the Secretary of Defense with respect to similar projects carried out under section 632(b) of the Department of Defense Authorization Act, 1985.
3. Enter into cooperative agreements with not less than five chiropractic colleges in five geographic regions.
4. Reimburse the veteran or make payment directly to the chiropractor furnishing services provided:
    a. chiropractic services were for treatment of a service connected neuromusculoskeletal condition of the spine,
    b. the veteran received care for such condition by the Veterans Administration within the preceding twelve-month period,
    c. expenditures for any veteran shall not exceed $600 per year, and
    d. total expenditures in any fiscal year for reimbursed chiropractic services shall not exceed $2,000,000.

Mr. Chairman, inasmuch as the Veterans Administration already has the authority to contract for chiropractic treatment, we would prefer to await the outcome of the Department of Defense's demonstration projects before imposing further requirements on the Veterans Administration. In addition, it is our understanding the cost involved could run as high as $7 million at a time of budgetary constraints.

This concludes my testimony and I will be happy to respond to any questions you may have. Thank you.

Resolution No. 635

CHANGE OF DATES FOR ENTITLEMENT UNDER THE PROVISIONS OF U.S. CODE, TITLE 38, SUBSECTION 101, (29) FOR VIETNAM ERA

WHEREAS, the United States of America, has recognized our involvement in Vietnam by awarding the Armed Forces Expeditionary Medal and the Navy and Marine Corps Expeditionary Medal for service in Vietnam for the period of 1 July, 1958 to 3 July, 1965; and

WHEREAS, the Armed Forces Expeditionary Medal and the Navy and Marine Corps Expeditionary Medals are awarded for honorable duty within specified geographical areas and specified times during periods of war, national emergency and for participation in specified, significant, military operations or service; and

WHEREAS, the United States of America has awarded the Vietnam Service Medal for the period of 4 July, 1965 to 28 March, 1973; and

WHEREAS, during the periods of 1 July, 1958 to 3 July, 1965 many of our Armed Forces personnel were in Vietnam, under a hostile environment, training South Vietnamese military personnel; and

WHEREAS, a number of our Armed Forces personnel were killed by the North Vietnamese troops; and

WHEREAS, the United States of America, through Congress, has amended U.S. Code, Title 38, subsection 101 (29) as follows: The term "Vietnam era" means the period beginning August 5, 1964 and ending on May 7, 1975; and

WHEREAS, presently, U.S. Code, Title 38, prevents veterans who served during the period of 1 July, 1958 to 3 July, 1965 from "Vietnam era" benefits; and

WHEREAS, most states adopt legislation affecting veterans benefits to conform with the dates as set forth in U.S. Code, Title 38; and

WHEREAS, many veterans and their dependents and widows are being denied Federal and State veterans benefits because of this unjust situation; and

WHEREAS, Senator Alan Cranston, Ranking Minority Member of the Senate Veterans Affairs Committee, has introduced legislation which would make eligibility for VA benefits under the provisions of U.S. Code, Title 38, for the Vietnam era coincidental with the dates of the Armed Forces Expeditionary Medal; and

WHEREAS, staff members of our National Veterans Service Committee have testified favorably on similar legislation in 98th Congress; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we seek legislation in the Congress of the United States

(Continued)

Resolution No. 635 - Continued

that will provide for recognization by the Veterans Administration, under the provisions of U.S. Code, Title 38, subsection 101 (29) by changing the dates of the "Vietnam era" now: beginning August 5, 1964 and ending May 7, 1975 to July 1, 1958 to May 7, 1975.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 635

Resolution No. 607

INCENTIVE THERAPY PROGRAM

WHEREAS, an intricate part of the treatment plan for many unmotivated patients in Veterans Administration Medical Centers is the Incentive Therapy Program; and

WHEREAS, this program pays a minimal "salary" to patients as an incentive toward their return to the community as a productive member of society; and

WHEREAS, the nonservice connected veteran in this program in receipt of pension is required to report the "payment" as "income," thus reducing the amount of pension; and

WHEREAS, this action removes the incentive from the program for veterans who lack the self-motivation to progress and places them in the position of paying for the work performed for the Veterans Administration; and

WHEREAS, if the program is successful, a number of these veterans may be returned to the job market, thereby regaining the dignity of self sufficiency and reducing the pension rolls; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we oppose the inclusion of income from the Incentive Therapy Program in determining entitlement to nonservice connected pension since it is counterproductive to the purpose of this program; and

BE IT FURTHER RESOLVED, that we urge Congress to pass legislation to rectify this situation which penalizes veterans undergoing incentive rehabilitation by amending Section 503, Title 38 U.S.C. to exclude income earned under Section 618, Title 38. U.S.C.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 607

Mr. **Principi**. Mr. Gorman.

Mr. **Gorman**. Thank you, Mr. Principi and Mr. Chairman.

In our written testimony today, we have covered in some detail, I believe, the numerous issues that are pending in the various legislation before the committee.

What I would like to do, with your permission, Mr. Chairman, is to address approximately seven issues that we would like to specifically comment on, the first being contained in S. 6, introduced by Senator Cranston.

Section 3 of that bill, would amend section 210(b) of title 38, precluding the administration from implementing a grade reduction without first submitting a detailed plan with justification for the reduction to the committees.

The DAV's primary interest in this regard has to do with direct patient care, as testified to, in part, by Mr. Lips this morning.

Those affected would be psychologists, social workers, physical therapists, pharmacists, audiologists, and so on.

Therefore, section 3 of S. 6 has the DAV's very strong support.

Additionally, section 4 of S. 6 would extend, until September 30, 1989, the VA's authority to provide hospital and medical care to Vietnam veterans exposed to agent orange and veterans exposed to radiation exposure.

Again, we think there's a need for this legislation and extension of that authority, and therefore we strongly support this measure, also.

Section 4 of S. 876, introduced by yourself, Mr. Chairman, would provide for a 3-year pilot program to be conducted in five geographic areas, providing community residential care for chronically mentally ill veterans.

I can state that the DAV is in basic agreement with the theory and certainly the intent of the measure. However, I would say that our support—or rather our two concerns that are contained in my written testimony be considered by the committee. And those are that a priority for receiving such residential care be accorded to the service-connected veteran.

And also I believe there will have to be a consensus reached whereby the VA will be required to pay for such care received by either all veterans in community residential care programs or in keeping with the current statutory language to provide no remuneration at all.

Both S. 6 and S. 876 provide for the conduct of a pilot program to evaluate the effectiveness, the feasibility, and the desirability to allow eligible veterans to receive needed health and health-related and/or social services that would obviate the need for hospital and nursing home care on a long-term basis.

Mr. Chairman, the DAV supports the intent of both measures, and we thank the authors for introduction of this legislation. We are particularly pleased with the provisions of S. 6, which accords priority for participation in this program to service-connected veterans and to utilize the geriatric evaluation units of the Veterans' Administration in conducting this program.

Mr. Chairman, with reference to S. 875—introduced by yourself would establish Vietnam veteran resource centers on a pilot basis at 10 existing readjustment counseling centers, for the purpose of increasing the overall effectiveness and the coordination of services furnished to eligible veterans.

In addition, the VVRC's will provide, in part, readjustment counseling, alcohol and drug rehabilitation and treatment, employment counseling, outreach and other services that could be provided by veterans' benefit counselors.

Again, Mr. Chairman, the DAV strongly agrees with the intent of this measure. However, we would suggest that should this measure be favorably reported that it be done so in consideration and harmony with the intent of the provisions of Public Law 98-160.

Senator Thurmond has introduced S. 1052, that would require the Veterans' Administration to provide chiropractic services to eligible veterans.

I can say that the DAV now, as we have in the past, supports the enactment of this legislation.

Chairman MURKOWSKI. I'm going to have to excuse myself. I have to vote now. I'm sorry.

Mr. GORMAN. Certainly.

The final measure that we would like to comment on is S. 1007, the Veterans' Health Care Promotion Act of 1985.

In our written testimony, we give rather detailed reasons for our opposition to this bill, with the exception of section 4.

We do not disagree with the general intent of the legislation that would require the VA to first consider and, in fact, where feasible and documented that it is reasonable, to go out and purchase an existing facility.

We just don't feel that the mandates, as contained in this legislation, would help to reach that end.

That concludes my testimony, Mr. Principi.

Mr. PRINCIPI. Thank you, Mr. Gorman.

[The prepared statement of David W. Gorman, assistant national legislative director for medical affairs, Disabled American Veterans, follows:]

PREPARED STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans, may I say how very much we appreciate the opportunity to appear here today.

Mr. Chairman, our testimony has been requested relating to the following legislation currently pending before the Committee: S. 6, the "Veterans Administration Health Care Amendments of 1985;" S. Amendment 22 to S. 6; S. 876, the "Veterans Administration Health Care Programs Improvement Act of 1985;" S. 875, the "Vietnam Veterans Resource Center Act of 1985;" S. 1007, the "Veteran Health Care Promotion Act of 1985; and the proposed "Veterans Chiropractic Services Demonstration Projects Act of 1985."

Additionally, our views were solicited on certain Administration proposed policy changes relating to VA health care including: third party reimbursement; a means test; and repeal of Section 610(a)(6), Title 38, United States Code.

We will discuss the provisions of each bill separately, save those provisions of S. 6 (Sections 5 and 9) and S. 876 (Sections 2 and 3), which are like in nature.

S. 6

Section I of the bill proposes to amend Section 101(29), Title 38, United States Code, to redefine the term "Vietnam Era" to include the period from February 21, 1961, through May 7, 1975 in the case of a veteran who served in the Republic of Vietnam during such period.

Mr. Chairman, the DAV--on previous occasions--has addressed similar proposals to redefine the beginning date of the Vietnam Era. Then, as now, although we have no official position on this provision, we would not object to its enactment.

In our view, enactment of this measure would have no impact on Vietnam veterans, nor would there be any additional benefits that would accrue to service-connected disabled veterans from this legislation. Additionally, it remains our feeling that, if enacted, all veterans who served from the date specified should be accorded the same status and type of benefits.

Section 3 proposes, through appropriate amendment to Section 210(b), Title 38, United States Code, to preclude the Administrator, in any fiscal year, from implementing a grade reduction affecting full time equivalent employees without first submitting a detailed plan and justification for such plan to the Committees on Veterans Affairs.

Mr. Chairman, though the DAV does not have a specific National Convention mandate on this particular issue, I can inform you that we strongly support enactment of this measure.

As you are well aware, the Office of Management and Budget (OMB) and Office of Personnel Management (OPM) have devised a plan which will decrease the number of GS/GM 11 through 15 positions in the government by 2% for four years beginning in Fiscal Year 1985. To effect these reductions, OMB has withdrawn funds from the VA's Fiscal Year 1985 budget. OPM will also monitor average grade and absolute reductions of GS/GM 11 through 15 employees.

Mr. Chairman, in discussing the issue of grade reductions, the DAV is principally concerned with the adverse impact this action will have in the Department of Medicine and Surgery (DM&S) as relates to direct patient care.

It is significant to note that approximately 65% of VA health care professionals come under the Title 38 personnel system. Additionally, of all Title 5 employees in grades 11-15, 68% are involved in direct patient care activities.

In addition to physicians, nurses and dentists, positions which are subject to the Administration's grade reduction plan include psychologists, social workers, physical therapists, audiologists, pharmacists, medical and laboratory technologists and dieticians.

Noteworthy is the fact that 39% of the federal work force is encompassed within the 11-15 grade level. Conversely, the VA's percentage of employees at these grade levels--Title 38 and Title 5--stands at about 26%, approximately equivalent to the private sector work force and well below the government-wide average.

Additionally, Mr. Chairman, while the average grade level, government-wide, is approximately 8.3, within the VA it is only 6.58.

It is clear to us, Mr. Chairman, that as an agency and, particularly, within DM&S, the VA is not "bulging" with employees in these grade levels. In fact, quite the opposite is true.

Our support of this measure is predicated on the belief that it will help cure the inequitable situation thrust upon the VA by OMB and OPM to reduce the number of employees that are so necessary to meet the health care mission of the Veterans Administration

Through appropriate amendment to Section 610(e)(3), Title 38, United States Code, Section 4 of the bill would extend, to September 30, 1989, the date that veterans exposed to dioxin or other toxic substances while serving in Vietnam or who were exposed to nuclear radiation may continue to receive hospital or nursing home care from the VA.

Mr. Chairman, the DAV has no official position on this issue, however, we strongly support its enactment.

Section 6 of the bill proposes to amend Section 618, Title 38, United States Code, to stipulate "...no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitation actively carried out pursuant to this section shall be included in determining annual income for purposes of pension payments."

Mr. Chairman, such activities are commonly known as incentive therapy (IT) and compensated work therapy (CWT). Participants in IT programs are assigned duties within the confines of a VA medical center and receive nominal hourly wages. Participants in CWT programs are able to learn work habits and/or vocational skills by working on projects under VA contract with private or other sources and earn wages comparable with those paid in the community for work of a like nature.

As we understand it, the intent of these programs is to permit veterans to develop increased levels of independence and feelings of self-worth that will minimize or alleviate the need for long term institutionalization.

Mr. Chairman, we understand the basic intent of this measure, as well as the positive impact IT and CWT have upon the lives of disabled veterans.

Nevertheless, the DAV has reservations concerning a blanket and total exemption of monies earned from these programs when considering the basic intent and integrity of the nonservice-connected pension program.

As an equitable alternative, we would suggest employing a formula to calculate the amount of monies earned that would be applied to countable annual income.

Example:

> For each dollar earned by a nonservice-connected pension recipient, 50 cents would be excluded in the computation of countable annual income up to a maximum of $400. All monies earned in excess of $400 would be considered as countable income for pension purposes.

As an illustration:

> Veteran A is paid wages of $400 for participation in the CWT program. The countable annual income for purposes of pension payment is $200.
>
> Veteran B is paid wages of $401 for participation in the CWT program. The countable annual income for purposes of pension payment is $201.

Mr. Chairman, we feel our alternative approach would continue to serve the basic intent of therapeutic and rehabilitation activities from a medical standpoint and, at the same time, preserve the integrity of the pension program.

Section 7 of the proposed bill would, by amendment to Section 3305(b), Title 38, United States Code, permit the disclosure of statistical information regarding VA health care programs, including information on aggregate morbidity and mortality rates associated with specific activities at individual VA health care facilities.

Mr. Chairman, the DAV has no official position regarding this measure and would not oppose its enactment.

Section 8 of the bill proposes to amend Section 4110, Title 38, United States Code, to permit disciplinary board actions involving any case in which a reduction or revocation of clinical privileges is proposed involving any person employed in a position described in Paragraph (1) of Section 4104 of Title 38, United States Code.

Mr. Chairman, the DAV has no official position on this measure.

S. Amendment 22 to S. 6

The stated purpose of this Amendment is technical in nature to conform with Section 612A(g)(1)(B) relating to the continued availability of readjustment counseling.

The DAV has no official position or objection to the enactment of this technical Amendment.

S. 876

As you know, Mr. Chairman, Section 4 of the bill proposes to amend Section 630 of Title 38, United States Code, mandating the Administrator to conduct a three year pilot program, in five geographic areas, to provide community residential care for chronically mentally ill veterans.

Eligibility to participate in the pilot program would be predicated upon the Administrator's determination that;

1. the veteran is suffering from chronic mental illness and is eligible to receive care under Section 610, Title 38, United States Code; and
2. without receiving the care furnished by a community residential care facility, the veteran would require hospitalization or nursing home care in a VA facility; and
3. by receiving such care, the veteran eventually will be able to reside in the community in a substantially self-sufficient manner.

In addition to referring and assisting eligible veterans for placement in a community residential care facility, the VA would be required to bear the cost of care provided.

Mr. Chairman, while the DAV is in basic agreement with the principal thrust and intent of this measure, we have two specific concerns that we feel must be addressed:

First, we are concerned with the absence of specific language that would accord service-connected disabled veterans a priority for participation in the program.

Secondly, we are concerned with the requirement that the VA "...shall pay..." all costs associated with the provision of such care.

Current law, Section 630(b)(3), Title 38, United States Code, specifically precludes the VA from assuming any financial responsibility for community residential care received by veterans.

Our concern is that similarly situated veterans requiring community residential care but without a chronic mental illness will be dealt with in an inequitable fashion.

Mr. Chairman, DAV support of this measure, therefore, will be predicated upon inclusion of language according a priority to service-connected veterans to participate in this program and a consensus reached wherein the VA will be required to pay the charges of community residential care for all veterans or a continuation of the current mandate to incur no costs for such care.

Section 5 of the bill proposes, through appropriate amendment to Chapter 73, Title 38, United States Code, to establish "...a comprehensive quality assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery to eligible veterans."

Mr. Chairman, we are aware that the Administrator has recently approved a realignment of the Department of Medicine and Surgery's Quality Assurance and Medical Inspector Programs.

It is our understanding that a Quality Assurance office, with a director, will be established to consolidate all quality assurance activities--including peer review organization and risk management--and report directly to the Chief Medical Director (CMD).

By placing these activities under the direct control of the CMD, emphasis will be placed on the critical importance attached to conducting a proactive program to identify and remedy, on a prospective basis, problems affecting the delivery of quality health care in the most efficient manner.

Mr. Chairman, the DAV has no official position on this measure. However, if the quality of direct patient care will be strengthened and/or improved, then we would have no objection to its enactment.

Section 6 of the bill proposes to establish an Advisory Committee on Veterans Administration Facility Planning.

Mr. Chairman, there is no doubt--as evidenced by hearings conducted by this Committee on March 26 and 27, 1985--that considerable controversy surrounds the VA construction process.

If, in the wisdom of this Committee and the Congress, a satisfactory remedy to that controversy may be produced by such an Advisory Committee, the DAV will not necessarily oppose enactment of this measure.

However, we would offer a word of caution and voice a concern regarding the proposal as currently constructed.

As you know, Mr. Chairman, various private sector concerns have publicly contended that the VA construction process is inefficient and have acknowledged a desire to become involved--in part or totally--with the construction of VA medical care facilities.

The cautionary note we wish to relate is that if such an Advisory Committee is established, it not be laden with individuals who have an inherent interest and/or conflict of interest in the private sector construction process.

Rather, individuals who are recognized as authorities in the field must be totally impartial, thus enabling them to offer meaningful and substantial input to address the issues regarding the VA construction program.

Additionally, Mr. Chairman, we are concerned with the inclusion as ex officio members, of the Secretaries of Defense and Health and Human Services. It is our opinion--with the vast difference in the mission of the VA compared to these Departments--that their participation may be of questionable value. However, we support the CMD, or his designee, to be included as an active, participating member of the Committee.

As mentioned earlier in my testimony, there are provisions in S. 6 and S. 876 that we wish to discuss concurrently, as they are similar in nature.

Section 5 of S. 6 and Section 3 of S. 876 propose to make permanent, through amendment to Section 620A, Title 38, United States Code, the VA's authority for furnishing care in the treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.

Mr. Chairman, the DAV does not have a specific National Convention mandate regarding this issue, however, we do not object to enactment of this measure.

Section 9 of S. 6 and Section 2 of S.876 contain provisions that would enable the Administrator to conduct a pilot program, in five geographic areas, to evaluate the effectiveness, feasibility and desirability of allowing veterans who are eligible for hospital and/or nursing home care to receive needed health, health related and/or social services that would obviate the need for institutional care.

Initially, Mr. Chairman, I want to state that the DAV supports the intent embodied in both bills. We have long advocated that providing necessary medical and certain non-medical services to veterans to avoid institutionalization is a desirable approach, both from a cost effectiveness standpoint and, more importantly, for the overall well-being of the veteran.

We endorse the provisions of both bills that would mandate the Administrator to provide "social services" (S. 876) and "health-related services" (S. 6) to veterans participating in such a program.

Mr. Chairman, to enable these provisions to succeed in their intent, we feel it desirable to define, in part, what is envisioned in the terms "social services" and "health-related services."

These terms should, in our view, include, but not be limited to

Domestic

- bathing
- feeding
- grooming
- changing patients clothes
- transporting patients
- oral hygiene
- dressing
- diet management

Homemaker

- housecleaning
- food preparation
- marketing
- washing clothes

Custodial

- assistance with daily needs
- turning patients
- catheter irrigation
- massage
- ambulation
- sitter services
- changing colostomy bags
- changing simple dressing
- changing external catheters
- medication administration
- assistance with prosthetic devices
- position adjustment/transfer

Mr. Chairman, because we believe that flexibility in providing these types of non-medical support services is necessary to obviate the need for institutionalization, we suggest, if this measure is favorably reported, that such services be defined as cited above.

We support, as proposed in S. 6, the involvement (in the pilot program), of Geriatric Evaluation Units (GEU) at VA health care facilities. The effectiveness of GEUs in the treatment of geriatric patients has, in our opinion, been proven to be of immeasurable value in improving the quality of care, as well as decreasing the rate of re-hospitalization of veterans.

Additionally, Mr. Chairman, we are pleased to note in the provisions of S. 6 that the Administration shall accord a priority for participation in the program to veterans with service-connected disabilities.

To insure that this intent is realized, we suggest inclusion of the proviso that not less than 50% of the participants in this pilot program be veterans with service-connected disabilities.

S. 875

This measure, introduced by yourself, Mr. Chairman, would establish a Vietnam Veterans Resource Center (VVRC) pilot program.

As we understand the intent of this measure, the Administrator would be required to establish and carry out a pilot program in ten existing Readjustment Counseling Centers (Vet Centers) to increase the overall effectiveness and coordination of services furnished to eligible veterans.

Envisioned in this measure is the ability of the VVRC to provide:

1. readjustment counseling and related mental health services authorized by Section 612A of this Title;
2. treatment and rehabilitation for alcohol or drug abuse dependence or alcohol or drug abuse disability;
3. employment counseling, training and placement services described in Section 2003A of Title 38, United States Code, in conjunction with employees of the Department of Labor referred to in such Section; and
4. outreach and other services authorized to be provided by VA veterans' benefits counselors

In addition to re-designating each of the involved Readjustment Counseling Centers, the mission of each Center would be converted to conform with the stated purpose of the pilot program.

Obviously, an increase in staffing at each center would be required to fulfill the mission of the VVRCs to provide unified care management to each eligible veteran participating in the pilot program.

Mr. Chairman, the DAV has continually expressed its commitment and concern toward assisting Vietnam Era veterans suffering psychological problems associated with their military service in

Vietnam. It was the DAV that provided funds for the "Forgotten Warrior Project" study which led, in October, 1978, to the DAV initiating its own Vietnam Veterans Outreach Program. The results of that study had a direct influence on not only our organization's establishment of a specific counseling program for Vietnam Era veterans but, we feel, on the decision of Congress to provide the necessary funds which authorized the Veterans Administration to create "Operation Outreach" and subsequently establish a network of "Vet Centers."

Mr. Chairman, although the VA's Psychological Readjustment Counseling Program had a slow and tremulous beginning, in our view, VA storefront Vet Centers have generally proven themselves to be successful in assisting Vietnam veterans and their families.

While we believe this program is necessary and will be utilized by veterans of the Vietnam Conflict in the future, we continue to strongly support the concept that the VA must plan to integrate these services into the mainstream of traditional and existing VA medical facilities.

While we do not disagree with the stated intent of S. 875, we suggest that, should this measure be favorably reported, it be done so in harmony with the intent of the provisions of Public Law 98-160, Section 101(b)(1).

Veterans' Chiropractic Services Demonstration Projects Act of 1985

This measure--introduced by Senator Thurmond--would authorize the VA to provide reimbursement of the reasonable cost for chiropractic care provided to eligible veterans.

Mr. Chairman, this measure would provide for the conduct of five demonstration projects in five geographic regions during the next three fiscal years.

In addition to furnishing chiropractic services to eligible veterans, the Administrator would be required to evaluate the therapeutic benefits and cost effectiveness derived by furnishing such care.

As you will recall, Mr. Chairman, in years past the Senate has favorably considered similar measures which would have, for all intents and purposes, required the VA to extend chiropractic services on a fee for services basis to veterans who needed or desired such care. However, these measures were not enacted into law.

Rather, both Veterans Affairs Committees, realizing the VA's existing authority to provide chiropractic services, have chosen an approach whereby they have urged the VA to substantially increase the number of referrals of veterans for chiropractic services.

Mr. Chairman, in our view, the VA has failed to exercise this authority to furnish chiropractic services and, at the same time, seemingly ignored the recommendations of the Committees to do so.

We believe chiropractic services, as part of the overall care and treatment of veterans, must be provided by the VA.

Because of the VA's reluctance--or refusal--to furnish chiropractic services, we believe the course of action to be taken is now clear. Therefore, in accordance with our National Convention mandate (Resolution No. 009) adopted by the delegates to our 1984 National Convention, the DAV strongly supports the enactment into law of this measure.

S. 1007

This measure--the proposed "Veterans Health Care Promotion Act of 1985"--would, through appropriate amendment to Section 5002, Title 38, United States Code, dramatically alter the manner in which the Veterans Administration acquires medical facilities.

Mr. Chairman, Section 2 of the measure would require the Administrator, in developing plans for new or replacement medical facilities, to first give consideration to leasing or purchasing existing medical facilities, as opposed to undertaking new construction.

Section 3 of the measure proposes to establish a pilot program under which the VA would determine the most cost effective method of acquiring medical facilities.

Additionally, the VA would be mandated to enter into a contract with a private sector concern to construct and operate a nursing home for the Veterans Administration. Funds for such construction would be furnished by the VA.

Also, Mr. Chairman, the VA would be required to enter into a similar contract that would enable a private sector concern to design and construct a medical facility for the VA which will then be leased or sold to the VA. In this instance, the VA would operate that facility.

Finally, Mr. Chairman, the VA would be required to acquire--by purchase of one and lease of another--two existing medical facilities and operate them with VA employees.

Mr. Chairman, Section 4 of the measure would require that the VA transmit to both Veterans Affairs Committees a report regarding the furnishing of respite care to elderly and disabled veterans. The DAV has no objection to enactment of this provision of the bill.

Section 5 of the measure would require the Administrator to transmit to both Veterans Affairs Committees an estimate as to the cost of increase, by 50% and by 75%, the number of community based nursing home beds available to the VA.

Additionally, Mr. Chairman, the Administrator would be "encouraged" to place as many eligible veterans as practicable in community nursing home facilities.

Finally, Section 6 of the bill would limit to $25 million the VA's expenditure of funds to purchase an existing medical facility and require the achievement of "savings in the cost of operating medical facilities under the jurisdiction of the Administrator..." in order to acquire an existing medical facility. Furthermore, such cost savings would have to be realized by reallocating resources from VA medical facilities that "...have a surplus of beds, are underutilized, or are converted to perform new missions."

Mr. Chairman, with the exception of the provisions of Section 4 of S. 1007, the DAV is vehemently opposed to enactment of this measure.

Our opposition to enactment of this measure is based, in large part, on the opinion that it is the precursor of what may be referred to as "mainstreaming" of veterans' health care into the private sector.

Mr. Chairman, we generally support the concept of acquiring additional hospital/nursing home care beds through the process of purchasing already existing medical facilities from the private sector.

The VA currently has statutory authority to "acquire" existing medical facilities. Additionally, we are aware of the existence of medical facilities that are currently available for purchase for various reasons. While we do not advocate the arbitrary wholesale purchase by the VA of existing facilities, we do support, in theory, the concept of VA acquisition of properties when it is documented that a need exists in a particular area in order to best meet the needs of the veteran population.

Mr. Chairman, this seems to be a viable and cost effective way to add badly needed beds to the VA system at a cost generally far below that of new construction and we would urge the VA to exercise its authority to do so when the opportunity presents itself and is justified.

However, because the VA currently has the authority to purchase existing medical facilities, we see no need to mandate them to do so.

Enactment of this measure would, in our view, serve only the enrichment--arguably unjust--of private sector concerns to become intimately involved, if not totally involved, in the process of providing health care to this nation's veterans.

Mr. Chairman, it has been established that providing health care to veterans directly by the VA is cost effective, as opposed to the same care being provided by the private sector.

While we do not question the motives of the authors of S. 1007 in introducing this measure, we certainly question the adverse affects enactment of this measure would have on the Veterans Administration and the provision of quality health care for this nation's disabled veterans. Though not intended, in our view, this measure has the effect of "mainstreaming" veterans health care and, as such, we do not favor its enactment as dictated by Resolution No. 202 adopted by the delegates to our most recent National Convention.

Eligibility for VA Health Care

Mr. Chairman, contained within the Administration's draft bill is a proposal to repeal Section 610(a)(6), Title 38, United States Code, which presently permits the Administrator to furnish hospital or nursing home care to any veteran for a nonservice-connected disability if such veteran is 65 years of age or older.

We believe the majority of veterans currently being treated in the VA are either service-connected, poor or medically indigent and elderly. In our view, repeal of this section of current law would have virtually no impact on the current users of the VA health care system.

Means Test

Mr. Chairman, the DAV is aware of the Congressional mandate--Public Law 96-330--requiring the VA to implement a means test to determine whether or not a veteran has financial resources which would allow him/her to receive medical care from the private sector as opposed to a VA medical facility.

Therefore, in our view, the VA can develop a fair and equitable means test, as they have had the authority to do for approximately four years.

However, in doing so, it must be drafted to reflect true need. Let no disabled veteran be required to spend down to some unrealistic, arbitrary level before being permitted to access the VA health care system. Make certain that no veteran is financially devastated by having to pay for a chronic or catastrophic illness. And insure that no elderly veterans are denied needed health care solely on the basis of their eligibility for Medicare or Medicaid.

Mr. Chairman, the episodes of inpatient care provided by the VA have remained virtually constant for the last ten years--1.2 million veterans treated in 1975 versus an estimated 1.4 million veterans to be treated in Fiscal Year 1986. Currently, there are approximately 28 million living veterans, of which about three million individual veterans were treated by the VA during 1983. The fact is that only one in nine veterans have ever used the VA health care system.

A 1978 study demonstrated that 71% of all veterans using the VA hospital system had incomes of less that $15,000--with nearly 25% having annual incomes of less than $6,000. Most patients--and almost two thirds of them were nonservice-connected disabled veterans--had no medical care coverage from any other source.

Mr. Chairman, we feel it accurate to state that the majority of veterans seeking admission to a VA hospital for treatment of nonservice-connected disabilities are poor and medically indigent. Therefore, with a means test in place, the number of veterans found to have available financial resources permitting them to obtain treatment from the private sector would, at best, be negligible.

Additionally, we would point out that the costs associated with administering the proposed means test would, in our opinion, negate or possible exceed any anticipated savings. Also, consider that any savings possibly realized by the VA would not be a saving to the federal government as a whole, but rather a transfer of costs to other programs such as Medicare and Medicaid.

Mr. Chairman, the Administration's legislative proposal that seeks to revise eligibility for VA medical care by amending Section 622, Title 38, United States Code, in addition to being inequitable, administratively burdensome and philosophically unsound, is totally unacceptable to the Disabled American Veterans.

In addition to the "spend down" requirement of this measure, we adamantly oppose those provisions that would require the VA to bill veterans for medical services furnished in "...extraordinary or emergency circumstances or for examinations conducted to determine if care is required..."

Simply stated, Mr. Chairman, it is our view that once a veteran is determined to have access for VA health care, it is philosophically unwarranted to "assess charges" for the medical care that is provided.

As we feel that the VA is capable of developing a realistic criteria to determine a veteran's ability to defray the necessary health care costs, we would request the Committee to encourage the VA to do so and reject any proposal that seeks to amend Section 622, Title 38, United States Code.

Third Party Reimbursement

Mr. Chairman, in view of the Committee's request that our written testimony be submitted by Friday, May 3, 1985 and the non-availability for our review of the Administration's proposal regarding third party reimbursements by that same date, we find ourselves at somewhat of a disadvantage to advance our views on a proposal that we have not yet seen.

We wish to publicly express our dismay and disappointment regarding the "stalling tactics" apparently employed by OMB in not releasing this proposal and/or the Administration's untimely manner in furnishing it to this Committee and the veterans' service organizations.

And, while we are prepared at this time to discuss, in general terms, our position regarding the presumed to be forthcoming proposal, we request that prior to any Committee "markup" consideration of third party reimbursement legislation, a public hearing be held for the express purpose of further detailed discussion.

Mr. Chairman, insofar as third party reimbursement is concerned, the DAV is adamantly and totally opposed to any legislative proposal that would give the VA the right to recover the cost of hospital, nursing home or outpatient care provided by the VA to veterans with private health insurance or similar coverage.

It is presumed that testimony will be heard today from representatives of the health insurance industry. I am sure that they will raise such issues as "constitutionality" and the effect that third party reimbursement would have on cost effectiveness, cost formulas and billing procedures

Our position and comments, however, absent the review of the actual proposed legislation, will concentrate on what we view to be the philosophical impact of third party reimbursement.

Medical care to this nation's veterans has been a time honored and readily bestowed benefit provided by Congress via the wishes and intentions of the American people. Making the provision of VA health care a cost sharing venture would, in our view, go against both the grain and the intent of the program and the desires of a grateful nation.

Mr. Chairman, it is our opinion that should this proposal be enacted into law, it could act as the precursor to a merging of the VA health care system into a national health care program whereby disabled veterans would be required to pay for their medical care. Also, a degree of discrimination may very well exist wherein the admittance to a VA facility of a nonservice-connected veteran with health insurance may take precedence over the admittance of an "as needy," or "more needy," veteran without such coverage.

Additionally, serious questions are immediately brought to our minds such as:

* Would the overall national health care cost increase without improvement in the quality of care furnished?

* Would a significant adverse change in the character and mission of the VA health care system be forthcoming?

* Would the much needed and desired cost containment efforts on a national level be diminished?

* Would the administrative burden imposed on the VA to effectuate acceptable billing procedures be overwhelming?

* Would resources designated for health care purposes be shifted to accommodate billing procedures?

* Would costly and time consuming litigation occur which may, in turn, lead to an exorbitant amount of resources being extended and delay encountered before the VA receives any reimbursement?

* Is the assumption regarding the extent of insurance coverage of veterans receiving VA care and the potential recovery accurate or, as we believe, highly speculative and inaccurate?

Finally, we would offer the following points for your consideration regarding the means test and third party reimbursement.

If a nonservice-connected veteran seeks medical care from the Veterans Administration and has, in some form, private health insurance, will he/she be able to access the system after undergoing the means test when health insurance is considered as an asset? We think not. Rather, it will be generally determined that the veteran is able to defray the cost of medical care and such veteran will be referred to the private sector for care.

If a nonservice-connected veteran seeks medical care from the VA and is able to satisfy the means test by demonstrating, based on available assets, that he/she is not able to defray the cost of necessary medical care, will that veteran, as a general rule, possess some form of health insurance? We think not.

Simply stated, it is our opinion that the majority of veterans treated in the VA from whom third party reimbursement could be collected would, at best, be negligible when consideration is given to the imposition of an already statutorily authorized means test. Therefore, any potential cost recoveries are virtually negated.

In concluding my testimony, I again wish to reiterate that we are extremely disappointed in not having had the opportunity to review the Administration's proposed third party reimbursement legislation. In view of this, I again want to state that our remarks today regarding third party reimbursement are general in nature and could be subject to change depending upon the specifics of the VA proposal.

We again request that we be given the opportunity of appearing before this Committee in a formal hearing to fully express our position or, at the very least, be given the opportunity, within a reasonable time frame of receiving such proposal, to submit a detailed statement for the record.

Again, Mr. Chairman, I thank you for the opportunity to appear here today to discuss these most important issues.

Mr. **Principi**. Thank you, Mr. Gorman.

Could you comment on the Vietnam Veteran Resource Center [VVRC] concept in S. 875, the Chairman's bill which combines VA medical and nonmedical services under one roof?

Do you believe that this approach could simplify the VA bureaucracy for the eligible veteran, especially the veteran who lives in a rural area away from VA facilities?

Anyone on the panel.

Mr. **Gorman**. I believe it could, Mr. Principi. But I also believe that if there's going to be a pilot program conducted on a 3-year basis and with the intent of Congress in enacting Public Law 98-160, that would transition the readjustment centers into the VA medical centers, I think maybe what can be learned from this program and this overall one-stop-center for services might be better utilized in the future if it is in a VA medical center, if that's where the readjustment counseling centers are going to ultimately exist.

Mr. **Principi**. There is a provision in our bill which does it together with the report that's due to the Congress.

Mr. **Egan**. As for The American Legion, we support the concept of the pilot project, and we certainly recognize the need for this kind of center, particularly in rural areas. But we would caution that the selection of the 10 sites to be used in this pilot be undertaken very, very carefully, so as not to interrupt the ongoing mission of the readjustment program and so as not to overburden particularly busy Vet Centers that are currently operating.

Mr. **Principi**. Mr. Schwab, do you have comments?

Mr. **Schwab**. Yes, sir; in our prepared text, we state that these centers may well be a duplication of the effort now being carried out in regional offices. Thus, it may serve a better purpose to place some or all of these veterans' resource centers in either a regional office or a VA medical center.

Mr. **Principi**. OK.

How about the concern that has been expressed that the people who visit the Vet Centers or the proposed VVRC's do not necessarily go to the regional office or to the VAMC, they turn to the Vet Center for services?

Mr. **Gorman**. I think those same individuals, Mr. Principi, would not be totally reluctant to come into the Vet Center, located at a VA medical center or on the medical center grounds.

Mr. **Principi**. Thank you.

Mr. **Egan**. We would have some concern to express about those individuals who would turn to the Vet Center for assistance, rather than to a regional office, if we had some available data to suggest that there was a serious problem.

There may very well be some data showing that, but we haven't seen it and therefore couldn't comment on it.

Mr. **Principi**. Thank you.

I have no further questions.

Mr. **Steinberg**. Mr. Gorman, could you expand a bit on the answer that you gave to Mr. Principi about how the experience gained in terms of moving staff out of the medical centers into these new centers, proposed in S. 875, would be helpful to the VA once it has to put the Vet Centers back into the medical centers in 1988 and beyond?

I was confused by your linkage of——

Mr. **Gorman**. I didn't intend, Mr. Steinberg, to make that linkage.

What I meant to say was that I believe that the VVRC's to be located in a VA medical center would serve a more useful purpose than to have the VVRC's located exclusively distant from the medical centers because——

Mr. **Steinberg**. I misunderstood you.

Thank you.

Mr. **Gorman**. OK. Thank you.

Mr. **Steinberg**. Do any of you have any comment to make on whether you would support the provision of drug and alcohol abuse care or counseling in the context of these centers located apart from VA medical centers—these newly proposed centers?

Mr. **Egan**. Well, it seems fairly clear that there are limits to the depth of treatment that can be available at Vet Centers for drug and alcohol rehabilitation.

I suspect that, in attempting to care for veterans with drug or alcohol problems, some decisionmaking has ultimately got to be made as to whether or not it's appropriate to send some veterans to the VA medical center, as opposed to maintaining outpatient treatment at the Vet Center itself.

I would defer to the readjustment counseling people as to what they thought they could handle; approaches to different kinds of problems are necessarily different. And again, to reiterate, as I said before, we certainly don't envision any undertaking in the Vet Centers that would be disruptive of the ongoing mission of the rehabilitation program.

Mr. **Steinberg**. Don, do you have any comment on that?

Mr. **Schwab**. Well, one of our concerns, of course, with the program is draining professional personnel from the medical center to work in the Vet Center. This would lead to exacerbating a condition—shortage of personnel and funds—that is already causing the VA to turn away a quarter of 1 million people a year from VA facilities. And this is one of our concerns with the program, although we support the concept of it.

Mr. **Steinberg**. Mr. Egan, with respect to your comment on S. 6 and the provision which Senator Cranston discussed with Dr. Gronvall and Dr. Brown earlier this morning insofar as the removal of clinical privileges, you expressed the view that you could support the proposal only if a protective mechanism is included to prohibit a situation such as the one you described where the life of the veteran might be in danger because of an inability to make an emergency suspension of clinical privileges.

I don't know if you were present when Senator Cranston asked Assistant General Counsel Hendricks whether or not the authority was implicit either in 4110 or elsewhere for the VA to make emergency suspensions now. And his answer was "yes." And he felt it would be similarly implicit that they could do so with respect to actions involving clinical privileges if they were required to go through 4110.

Would that satisfy your concern——

Mr. **Egan**. First of all, Mr. Steinberg, I was present at that time. And I think it's important to recognize that the VA has authority to do a good many things that it doesn't do. And that's not to say that in this instance the VA is not exercising that authority.

Whether or not they have——

Mr. STEINBERG. I think, in fact, the VA is exercising that authority. I think we all know of cases where VA physicians were suspended from any direct contact with patients, without going through any due process mechanism, let alone 4110.

Mr. EGAN. Well, the questions are whether or not that authority ought to be discretionary and whether or not that authority ought to be given the force of law.

We feel that if the patient's life is in danger, the authority ought to be given the force of law.

Mr. STEINBERG. But you would favor such an amendment to title 38 regardless of what is done with respect to this notion of suspension of clinical privileges?

Mr. EGAN. That's correct.

Mr. STEINBERG. Don, you did not, because of the time constraints in your oral presentation of your longer remarks, make reference to section 3 of S. 6, which deals with the grade reductions. I wonder if you wanted to take a moment to express your position on that?

Mr. SCHWAB. Well, I think it's essential that section 3 be enacted into law, because of the swiftness with which the administration moved in this grade reduction program, in accordance with the Grace Commission report; even though DM&S has gotten some exemption from that, title 5 employees have not been exempted. And the VA still has to take the dollar amount out of its hide somewhere.

Mr. STEINBERG. Yes; I think that's exactly right. In fact, I believe that the dollar amount is upwards of $60 million over the next 4½ fiscal years.

Mr. SCHWAB. That one provision should be included in whatever legislation is advanced.

Mr. STEINBERG. Thank you.

In closing, I'd just like to thank each of you for your generally favorable and, where not favorable, at least constructive comments on Senator Cranston's legislation and also to note that you obviously had a rather massive task in preparing for this hearing with such a multiplicity of provisions before the committee. And I congratulate you for some very helpful testimony.

Mr. PRINCIPI. The final panel: Colonel Passamaneck, Mr. DeGeorge, and Mr. Rhoades.

Colonel Passamaneck, you may begin.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF: LT. COL. DAVID J. PASSAMANECK, U.S. ARMY (RET.), NATIONAL LEGISLATIVE DIRECTOR, AMVETS; FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND DENNIS K. RHOADES, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Colonel PASSAMANECK. Thank you, Mr. Chairman.

AMVETS appreciates the opportunity to offer our views on the administration's proposed policy changes relating to VA health-care programs, and proposed legislation affecting care and Vietnam veterans' consultative services.

We have endeavored to make it clear in our testimony on the 1986 VA budget, as well as in our recent policy presentation by our national commander, John Lorec, that the administration's proposals relating to eligibility for non-service-connected health-care are a sickening betrayal of that segment of our Nation's veterans who are most in need of the support of the Government for which they risked their lives.

During this trying period, when all Americans who love this country and its way of life are sincerely searching for ways in which to reduce Government expenditures, and consequent deficits, without raising taxes, veterans are frequently being asked to sacrifice portions of the entitlements which they fought for in peace and war since the close of World War I.

Where shall we find the money for our veterans programs within restricted budget limits, we are asked. AMVETS' response to that challenge cites, by way of example, the over $19 billion a year the Government is spending on programs to artificially support farm commodity prices. Needless to say, if the President had kept his promise in 1980, to abolish the useless expensive Departments of Energy and Education, there would be more than enough funds for veterans programs.

The agricultural subsidies scandal, together with many other Government schemes for pumping untold billions into the pockets of middle-level business and labor interests are the real sacred cows with which Mr. Stockman should be concerned.

Regarding the proposed legislation being considered here, we have a few comments. The proposal for a pilot program for noninstitutional care of chronically ill veterans deserves a fair trial. AMVETS prefers the provisions of S. 876 but S. 6 also has great merit.

In giving provisional endorsement to this proposal, we understand that the plan does not contemplate mainstreaming elderly veterans into non-VA facilities as part of a scheme to curtail the VA health-care system. We believe the proposed permanent establishment of the alcohol and drug treatment program, with careful monitoring, as set forth in S. 876, is warranted, as is the proposal for community residential care for chronically mentally ill veterans, with of course, the caveat concerning mainstreaming.

We concur with the provisions of proposed sections 4151 and 4152 of title 38, relating to quality assurance, but believe that the proposal to establish a facility advisory committee may well result in a mini-Grace Commission, supporting mainstreaming.

Moreover, when we are trying to save money, we don't need another bureaucratic monster to usurp the functions of DM&S, and the construction offices of the VA.

The provisions of S. 875, establishing pilot resource centers, manned by professional personnel will hopefully result in badly needed improvement in the quality of service which is now supposed to be provided by the Vet Centers.

We believe that this service should not be restricted, however, to Vietnam veterans. The time for special handling of the Vietnam veteran has just about passed.

AMVETS opposes the restrictions on VA personnel management, proposed by section 3, of S. 6. The Constitution places the executive power in the President. Although we adamantly oppose mass grade slot reductions, particularly in the GS-11 through GS-15 categories, we do not believe the VA can be efficiently managed by congressional committees and/or the General Accounting Office. If congressional intercession occasionally is required to prevent unwarranted reduction, so be it. But, transferring the basic executive responsibility to Congress is no solution.

Incidentally, in this connection, we have been for some time, and are especially concerned about the tremendous administrative costs imposed on the VA in terms of personnel and otherwise, in accomplishing these massive reporting projects. They are all too frequently imposed upon the VA by the Congress. We would rather see these people employed in serving veterans rather than shifting paper at central office.

The provisions of subsection E, section 610 of title 38, were enacted as a temporary spur to the expeditious completion of the agent orange epidermiologic study. The subsection should not be amended. At the conclusion of the study, we can take another look at this matter.

The proposed amendment of section 618 and S. 6, relating to therapeutic income should also apply to eligibility for non-service-connected medical care, just in case we end up with an enforced means test. We accept the proposed amendment of section 4110 in the interest of fairness.

During a period of preserving veterans' programs from irresponsible assaults by ruthless budget cutters who have no respect for veterans or military service, is no time to open up a pandora's box by suggesting the inclusion of civilians in VA programs, or similar programs administered by other Federal agencies. We cannot, therefore, accept section 10 of S. 6.

We have no quarrel in principle of subsection 2(a) of S. 1007, introduced by Senators Boschwitz and Denton. If suitable existing medical facilities can be purchased or leased for VA use at a saving, we can see no reason why we should not use them. However, there is a danger that this provision will subject the VA to intense political pressure to bail out marginal private hospitals.

The mandated pilot programs designed to use the VA as a laboratory for comparative analysis of facilities constructed by the VA and those constructed by private medical service suppliers is entirely too restrictive and intrusive into the necessary discretionary management authority of the VA. It reeks of mainstreaming.

The report on plans for respite care may do some good, but AMVETS adamantly opposes using it as a device for turning aged veterans out of the VA system, with the object of saving money rather than providing the optimum care. We would suggest as an alternative H.R. 505, introduced by Mr. Edgar of Pennsylvania.

Sections 5 and 6 of S. 1007 appear to be blueprints for phasing out the VA medical care system as we know it. One wonders whether Mr. Grace had a hand in drafting them.

Senators Thurmond and DeConcini's bill to provide chiropractic services on a pilot basis within the VA system is intelligently based on the demonstrated needs of veterans rather than monopolistic interests of the American Medical Association. It is long overdue.

Even though AMVETS does not go along with all the proposals as set forth in the legislation being considered here, we deeply appreciate the compassion and courage of you, Mr. Chairman, and Senators Dole, Byrd, Cranston, Denton, Boschwitz, Thurmond and DeConcini in addressing with intelligence and imagination several of the problems of veterans in need of remedy.

Thank you.

Mr. Principi. Thank you, Colonel Passamaneck.

[The prepared statement of Lt. Col. David J. Passamaneck, U.S. Army (retired), national legislative director, AMVETS, follows:]

PREPARED STATEMENT OF LT. COL. DAVID J. PASSAMANECK, U.S. ARMY (RET.), NATIONAL LEGISLATIVE DIRECTOR, AMVETS

AMVETS appreciates the opportunity to offer our views on the Administration's proposed policy changes relating to VA health care programs and proposed legislation affecting health care and Vietnam veterans consultative services.

We have endeavored to make it clear in our testimony on the 1986 budget, as well as in our recent policy presentation by our National Commander, John Lorec, that the Administration's proposals relating to eligibility for nonservice-connected health care are a sickening betrayal of that segment of our nation's veterans who are most in need of the support of the government for which they risked their lives.

We are now seeing the results of the "intensive scrutiny" of VA programs which was promised by the Office of Management and Budget when the 1985 Budget was presented. The most outstanding characteristic of the 1986 VA Budget, which is approximately $100 million less than last year, is that it represents the first turnaround in a policy of gradual, but steadily improving entitlements and services for veterans and their dependents since the depression of the 1930's. The apparent solution, as far as the Administration is concerned, for the impending 40% increase in veterans 65 and over by the year 2000, with the attendant need for intense development of geriatric care systems, is to cut the heart out of the VA medical program with the immediate objective of removing all but service-connected disabled from the rolls of those eligible for VA medical care, and ultimately to provide such care for combat and instrumentality of war disabilities only. This objective was clearly set forth in the concluding discussion on the VA in the by now notorious report of the President's Private Sector Survey on Cost Control (the Grace Commission) whose Chairman, J. Peter Grace, is also the Chief Executive Officer of one of the largest private suppliers of nursing home and other medical services. The same policy objective was reaffirmed by recent White House inquiries of the VA regarding the expected work load if health benefits were limited to veterans with service-connected disabilities.

On the inspiration of David A. Stockman, the Director of OMB, the Administration is seeking legislation to cancel the current space available entitlement to medical care for veterans 65 and older, regardless of economic need, and require all nonservice-connected veterans who were not POW's and who are not on the pension rolls or Agent Orange claimants to pass what amounts to a pauper's test in order to receive medical treatment from the VA. Millions of sick, elderly veterans would be turned away from VA clinics and hospitals under this plan. This same David Stockman, who has demonstrated unmitigated contempt for veterans and retired military is the young man who enrolled in Harvard Divinity School during the Vietnam war in order to avoid military service. In other words, this draft dodger is now leading the assault on military personnel entitlements and veterans programs on behalf of a President who otherwise appears to be sincerely interested in bolstering our national defense posture.

When confronted with serious questions posed by AMVETS and other veterans groups regarding the cost of implementing the suggested "means test" at the VA's briefing on the budget, the leadership of the VA shrugged their shoulders in bewilderment, but made it clear that the cost of driving millions of elderly veterans from VA facilities would, indeed, be tremendous. Of course, no mention was made of the veterans who discouraged by the abuse and red tape which would be involved in enforcing the "means test" simply would not even attempt to seek necessary, often preventive treatment to stay the onset of degenerative geriatric conditions. To further impair the ability of veterans to secure adequate health care, the budget also calls for intensive third party collection from insurers, with the resulting sharp increase in premiums and restriction in coverage.

During this trying period when all Americans who love this country and its way of life are sincerely searching for ways in which to reduce government expenditures and the consequent deficits, without raising taxes so as to bring on another recession with more inflation and unemployment, veterans are frequently being asked to sacrifice portions of the entitlements which they have fought for in peace and war since the close of World War I.

Where shall we find the money for our veterans programs within restricted budget limits? That is the challenge which veterans are expected to meet by sharing in across-the-board freezes and cuts of all federal benefit programs, with no distinction made between unearned welfare and charitable programs and the dearly earned entitlements of veterans, including our retired military members.

AMVETS response to that challenge cites, by way of example, the over 19 billion dollars a year the Government is spending on programs to artificially support farm commodity prices, and store the astronomically expanding surplus of farm products to subsidize a relatively few marginally inefficient farm speculators, with the result of driving American farm products off the world market. Let's do something about this vast give-away program to one small segment of our private economy at the expense of millions of consumers, before we even suggest sticking a knife into the backs of our veterans. Needless to say, if the President had kept his promise of 1980 to abolish the useless and expensive Departments of Energy and Education there would be more than enough funds for veterans programs.

The agricultural subsidy scandal, together with many other government schemes for pumping untold billions into the pockets of middle level business and labor interests are the real "sacred cows" with which Mr. Stockman should be concerned.

Mr. Chairman, you and Senators Cranston, Denton, Boschwitz and Thurmond have proposed legislation to provide non-institutional care to chronically ill veterans who might otherwise be eligible for nursing home care, develop cost/effective methods for acquiring medical facilities and evaluating chiropractic services. Both you and Senator Cranston have proposed changes in the Alcohol and Drug Dependence Treatment Program. Additional provisions of S.6, sponsored by Senator Cranston, and S.876, sponsored by you, Mr. Chairman, provide for changes affecting health care quality assurance. In addition, S.876 provides for a pilot program for chronic mental illness in community residential care facilities, and the establishment of a VA Facility Planning Committee.

S.6 also provides for congressional control of VA personnel grade reduction; cutting off special Agent Orange and Radiation health care eligibility in 1989; exempting income generated by therapeutic activity from being classified as "income" for pension purposes; accessibility of statistical information, notwithstanding the Privacy Act; and the right to a hearing for those facing revocation of clinical privileges under Section 4110 of Title 38, United States Code. S.6 also mandates a study of the feasibility of providing VA-type benefits to civilian volunteers who served in Vietnam for at least 30 days, during the Vietnam War.

The proposal for a pilot program for non-institutional care of chronically ill veterans deserves a fair trial. AMVETS prefers the provision of S.876, but S.6 also has merit. In giving provisional endorsement to this proposal, we understand that the plan does not contemplate mainstreaming elderly veterans into non-VA facilities, as part of a scheme to curtail the VA health care system.

We believe the proposed permanent establishment of the alcohol and drug treatment program with careful monitoring as set forth in S.876 is warranted, as is the proposal for community residential care for chronically mentally ill veterans, with, of course, the caveat concerning mainstreaming.

We concur with the provisions of proposed Sections 4151 and 4152 of Title 38 relating to quality assurance but believe that the proposal to establish a facility advisory committee may well result in a mini-Grace Commission supporting mainstreaming. Moreover, when we are trying to save money we don't need another bureaucratic monster to usurp the functions of DM&S.

The provisions of S.875, establishing pilot resource centers manned with professional personnel will hopefully result in badly needed improvement in the quality of service which is now supposed to be provided by the Vet Centers. We believe that this service should not be restricted, however, to Vietnam veterans. The time for special handling of the Vietnam veteran has just about passed.

AMVETS opposes the restrictions on VA personnel management proposed by Section 3 of S.6. The Constitution places the executive power in the President, and, although we are deeply concerned with suggested mass grade and slot reductions, we do not believe the VA can be efficiently managed by congressional committees and/or the General Accounting Office. If congressional intercession occasionally is required to prevent unwarranted reductions, so be it, but transferring the basic executive responsibility to Congress is no solution.

The provisions of subsection (e) Section 610 of Title 38 were enacted as a temporary spur to the expeditious completion of the Agent Orange epidemiologic study. The subsection should not be amended. At the conclusion of the study, we can take another look at this matter.

The proposed amendment of Section 618 in S.6 relating to therapeutic income should also apply to eligibility for nonservice-connected medical care, just in case we end up with an enforced "means test." We accept the proposed amendment of Section 4110 in the interest of fairness.

During a period of preserving veterans programs from irresponsible assaults by ruthless budget cutters who have no respect for veterans or military service is no time to open up a pandora's box by suggesting the inclusion of civilians in VA programs, or similar programs administered by other federal agencies. We cannot, therefore, accept Section 10 of S.6.

We have no quarrel, in principle, with Subsection 2(a) of S.1007, introduced by Senators Boschwitz and Denton. If suitable existing medical facilities can be purchased or leased for VA use at a saving, we can see no reason why we should not use them. However, there is a danger that this provision will subject the VA to intense political pressure to bail out marginal private hospitals. The mandated pilot programs designed to use the VA as a laboratory for comparative analysis of facilities constructed by the VA and those constructed by private medical service suppliers, operated in the case of a nursing home by employees of the contractor, is entirely too restrictive and intrusive into the necessary discretionary management authority of the VA. It reeks of mainstreaming. The report on plans for respite care may do some good but AMVETS adamantly opposes using it as a device for turning aged veterans out of the VA system with the object of saving money, rather than providing the optimum care!

Sections 5 and 6 of S.1007 appear to be blueprints for phasing out the VA medical care system as we know it. One wonders whether Mr. Grace had a hand in drafting them.

Senator Thurmond's bill to provide chiropractic services on a pilot basis within the VA system is intelligently based on the demonstrated needs of veterans rather than the monopolistic interests of the AMA. It is long overdue.

Even though AMVETS does not go along with all the proposals as set forth in the legislation being considered here, we deeply appreciate the compassion and courage of you Mr. Chairman, and Senators Cranston, Denton, Boschwitz and Thurmond in addressing with intelligence and imagination, several of the problems of veterans most in need of remedy.

Mr. **Principi**. Mr. DeGeorge.

Mr. **DeGeorge**. Good morning, Mr. Principi, and thank you, Mr. Steinberg.

PVA is in favor of Senator Cranston's bill, S. 6, section 2, which recognizes and extends the duration of the hostile action on the Republic of Vietnam. The proposal is justifiable and can be verified. Clearly, the impact of service under hostile fire is in no way, nor should it be, mitigated by arbitrary dates.

Veterans who experienced hostile fire are the same, whether it is during a declared war, a police action, or any other circumstances.

Further, PVA also recommends consideration for war time benefits to be provided to those who served in Lebanon and Grenada, for the same reasons.

PVA is in favor of section 3, as this amendment will at least provide Congress an awareness in timely control of any attempts without justification for further grade reductions in the future.

Section 5, PVA is in favor of, to the point that we look forward to and anticipate with great interest the efforts and the reports of this program as it pertains to the operation of viable alcohol and drug treatment and rehabilitation programs.

Section 6, PVA strongly favors and applauds this amendment, which excludes as income, for the purposes of pension payments, any remuneration an individual receives as a participant in therapeutic or rehabilitative programs. The present situation is counterproductive and serves as a disincentive to younger, catastrophically disabled, non-service-connected veterans in their attempts to rejoin the work force.

I might also interject and take the time here to thank this committee for having worked with PVA in the enactment of legislation on the Public Law 98-543, Veterans Benefits Improvement Act of 1984. As PVA was a leader in this legislation, and with the help of this committee, we were able to see it enacted. We are looking forward to favorable approval and passage of section 6. Again, thank you for that.

Regarding section 9(a)(1), PVA is also in favor. We also commend Senator Alan Cranston and Senator Murkowski in relationship to S. 875, for their efforts to introduce and address the needs of veterans by creating a pilot program of noninstitutional treatment programs.

PVA supports a resident care program that offers alternative initiatives for care, and to provide assistance not only to the aging veteran, but also to the catastrophically disabled veteran. I point out that we're adding the clause "catastrophically disabled veteran," and would hope that this legislation could be amended to include catastrophically disabled veterans, regardless of age.

We do believe that resident care programs that serve the chronically disabled can be cost effective while serving the needs of the provider, the consumer and the care-giver.

Finally, in this area, the PVA is in support of S. 6, but would strongly advise, and again to repeat, urge the chairman, that implementation of the resident care program should include younger as well as the catastrophically disabled service- and non-service-connected veterans, with priority provided to service-connected veterans, of course.

PVA also supports section 9(b) of S. 6 because it does provide research programs within the geriatric research education clinical centers programs. We only ask that these studies include and recognize the needs of aging spinal cord injured veterans in their research study as well.

Section 9(a), the appointment of a VA employee to serve as case manager, to coordinate the provisions of health services of an agency other than the VA to veterans is imperative. We feel that would provide the control by the Veterans' Administration of these kinds of programs, so that we aren't fearful of what has been termed as "mainstreaming." PVA is in favor of section 9(a).

Section 10(a)(1). PVA is in favor of this section, but only to evaluate the question, to report on Federal Government responsibility to individuals who served with voluntary civilian organizations in Vietnam. This effort is humanitarian in approach, but we believe premature at this time, as PVA's primary concern is meeting the unmet needs of veterans today, who have served in the uniformed services.

I notice the light is going on. If you will just let me get one more point in here.

Under Veterans' Outreach Centers, resource centers; we're totally in favor of this program, but would also add the caveat that, as 612(a) of title 38 says, ". . . the program may allow physicians and psychologists to go into the centers." PVA is adamantly opposed to any medical practitioners going into resource centers to provide any assistance whatsoever. That kind of care that is needed by veterans, that those veterans be referred to VA medical centers, outpatient clinics, and/or as authorized, military facilities.

On that point, I will conclude my comments.

Mr. PRINCIPI. Thank you, Mr. DeGeorge.

[The prepared statement of Frank R. DeGeorge, associate legislative director, Paralyzed Veterans of America, follows:]

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PREPARED STATEMENT OF FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, it is a pleasure for Paralyzed Veterans of America to appear today and present the views and concerns of its members on the various legislative proposals being addressed. These proposals cover a wide range of health-care issues, which affect our members and other veterans. I am Frank R. DeGeorge, Associate Legislative Director of Paralyzed Veterans of America.

We will address the legislative proposals in the order as listed. Our initial comments refer to the "Veterans' Administration Health-Care

Amendments of 1985," S.6, introduced by Senator Alan Cranston. PVA is in favor of Section 2, a legislative proposal to amend Section 101(29), Title 38, Definition of Vietnam Era, that recognizes and extends the duration of the hostile action in the Republic of Vietnam, a period that U.S. servicemen and servicewomen served in the military. The proposal is justifiable and can be verified; possibly, for different reasons than others, PVA supports the effort to extend benefits to those eligible veterans who have served in hostilities prior to August 5, 1964 and/or subsequent to May 7, 1975. Clearly, the impact of service under hostile fire is in no way, nor should it be, mitigated by arbitrary dates. The results and potential consequences for veterans who experience hostile fire are the same, whether it is during a declared war, a police action or any other named circumstance.

PVA, in its supportive role also recommends that war time benefits be provided to eligible veterans who have served in hostilities in Lebanon and Grenada, who served honorably, were wounded or killed. To repeat, we respectfully remind the nation that those who served during any hostile action are deserving of the full range of VA services and benefits, which veterans of war time service duly received; yet, for many this remains an unfulfilled obligation.

PVA strongly supports the efforts of Senator Cranston's as Section 3 will amend Section 210(b) by adding (3)(A)(i), which prohibits the VA Administrator from implementing grade reductions without submitting first to the Senate and House Committees on Veterans' Affairs a report containing a detailed plan for such reduction, to include the Administrator's justification, data and determination.

PVA's favorable support of this amendment is based on previously expressed concerns in opposition to proposals and arbitrary directives of the Office of Personnel Management (OPM) and the Office of Management and Budget (OMB); this policy reduces the total number of federal mid-level professional employees within the General Services Administration (GSA), grade classification of GS11 through GS15, by two percent each year for five years. This effort affects the Veterans Administration's ability to provide quality health care to the nation's veterans within its existing health care delivery system. This plan is misguided (by the Grace Commission) and ill conceived, and is offensive to federal employees, all veterans, and to PVA as an organization. OMB's very own statistics clearly indicate that the VA is operating an austere management team in its health care delivery system.

The Cranston amendment will, at the least, provide Congress an awareness and timely control of any attempts without justification of further grade reductions in the future. Presently, the VA's department of Medicine and Surgery (DM&S) is operating at a 27 percent level of mid-management staffing, where government wide the mid-management grade bulges to 39 percent. Any and or all grade reductions at any level would be detrimental to the VA's mission to provide quality care.

As PVA commented before this august body on February 20, 1985, on the proposed budget, we would now say, if it is within the purview of "Uncle Sam," as an employer to request pay cuts of five percent and in addition grade reduction of his workers, then we must be concerned with the wisdom of the Administration and the request must be questioned, especially if increased productivity, good employee morale, retention of a good labor force, quality of service, is desired. Without adequate staffing, the VA medical system will not be able to provide the quality or quantity of service which is needed, as in the past, present, and in the future at a time when preparation and concern for demands being placed on the system, as the aging veteran population increases.

PVA has already received many calls from field personnel expressing concern over the devastating effects that the grade reduction initiative is having at the local VAMC level of operation. We can attest to low employee morale, situations where mid-level managers are having to work extended hours to compensate for lost or unfilled staff positions, failure to recruit needed management staff because of VACO imposed hiring freeze and/or lack of upward mobility that has resulted from the OMB/OPM initiative.

We would remind the Committee of the Hayes study (Committee print 98-16) which was recently completed for the House Committee on Post Office and Civil Service that indicates government workers are presently underpaid as compared to their private sector counterparts. The study also reveals that this disparity in pay becomes even more disproportionate as one increases in the GS classification schedule. For example, the Hayes study shows that a federal worker rated at the GS-11 level receives on the average $28,653 per year in cash compensation while his private sector counterpart receives an annual cash remuneration of $30,524 for differential of $1,929. A GS-15 rated employee on the other hand earns, on the average $51,067 per year while his private sector counterpart equivalent is being paid an average salary of $64,102 per year, or $13,000 more. The Grace Commission and the OMB/OPM grade reduction initiative fails to take this matter into account when advocating its GS 11-15 "grade bulge" and therefore, this initiative only serves to exacerbate an already regretful and difficult situation faced by federal workers.

Section 5 - PVA is in favor to amend Section 620A, et al, which provides for the Administrator to issue a report of the findings and recommendations of the Administrator in FY86, FY87, and FY88 pertaining to the operation of the Alcohol and Drug Treatment and Rehabilitation Program(s) - (due March 1st of each year). PVA looks forward in anticipation and with great interest in the efforts and reports of this program.

Section 6 amends Section 618 (b) - PVA strongly favors and applauds this amendment, which excludes as income for the purposes of pension payments any remuneration an individual receives as a participant in therapeutic or rehabilitative programs. The present situation is counter productive and serves as a disincentive to younger catastrophically disabled nonservice-connected veterans in attempting to rejoin the work force. This amendment would enhance the purposes of enacted legislation, "Veterans Benefits Improvements Act of 1984," P.L. 98-543, designed to assist veterans via education and rehabilitation programs. Please allow us to interject our appreciation to the committee for their support of this legislation, in which PVA was highly involved.

For several years, PVA has addressed the work disincentives in the NSC pension program and removal of payments for rehabilitative activities as counted income is a significant beginning in making this program a viable one for younger disabled pension recipients. To count as income educational or vocational training benefits, places an onerous burden on a pension recipient who is attempting to gain new skills necessary to regain employment. Far too often the catastrophically disabled nonservice-connected veteran is precluded from even making such an attempt due to the financial hardship created by the existing situation.

PVA views enactment of this provision as a cost-effective measure. Successful completion of a rehabilitative program, which results in employment, not only removes the veteran from the pension program, and more, but also places the veteran in the position of being a contributing, tax paying citizen. This effort coupled with the other recommendations made by PVA over the past several years regarding the removal of work disincentives in the NSC pension program will greatly enhance the viability of the program and will assist many younger, catastrophically disabled NSC veterans in returning to employment and more productive lives.

Mr. Chairman, PVA is in favor of Section 9 (a)(i), and also commends Senator Alan Cranston, and, Senator Murkowski in S. 875, for their efforts to introduce and address the needs of veterans by creating a pilot program of noninstitutional treatment programs. As we understand it, the health related services program also includes a "Respite Care" program. We strongly support the provision of Section 9, which addresses respite care. Several federal programs and agencies currently have means for providing respite care and these efforts have proven extremely beneficial in obviating the need for in-patient care when a supportive spouse or significant other is temporarily unable to care for the ill or disabled individual. The proposal for the Administrator to report to Congress on respite and hospice care is a needed and overdue action, which hopefully will lead to improved programs for chronically and terminally ill veterans.

For many catastrophically disabled veterans the role of family members is indispensable to their well-being. Frequently, due to no change in their own condition, they must rely upon expensive in-patient care when a supportive family member is temporarily unable to continue care provision. Hopefully, the report of the Administrator will also address the need for respite care to alleviate the psychological burdens placed on family members. Often the day-to-day care provided by a family member is overlooked even though it is essential in precluding a veteran's institutionalization. Periodic relief is needed for the supportive family member to provide for that individual's well-being, as well as, that of the chronically ill or disabled veteran.

Realizing full well the ever increasing costs associated with hospital health-care, especially for the chronically ill or long-term disabled veteran, alternatives to institutional care need to be developed. PVA, based upon its own knowledge of the subject and by the research obtained, delving into the role of the "significant other," as it portends for the aging SCI veteran, strongly supports the implementation of a VA sponsored respite care program. Respite care is a concept that provides short term relief from the responsibilities of caring for a chronically ill or disabled family member, while helping to maintain family equilibrium. Respite care programs serve elderly or impaired individuals who want to remain at home, and care givers who want to care for the relative or spouse at home.

PVA supports a VA respite care program that offers assistance not only to the aging veteran, but also to the catastrophically disabled veteran, regardless of age. Senator Murkowski's bill S.875, which is similar to S.6, provides for respite care for catastrophically disabled, and PVA would encourage adoption of this provision by amending S.6 to include catastrophically disabled veterans. We believe respite care programs that serve the chronically disabled can be cost effective while serving the needs of the provider, the consumer, and the care giver.

In PVA's testimony delivered on June 13, 1984, before the House Subcommittee on Hospitals and Health Care, Dr. George Hohmann, Ph.D., expressed concern for the aging SCI veterans who seek assistance in the home or dormitory home to alleviate the need for admittance to VA medical centers and nursing homes. A respite care program is very much needed for the SCI veteran attempting to return to and maintain personal residancy in the home environment.

To maintain the SCI veteran in the home dictates providing support services to both the veteran and his family care givers. Respite care programs are ideal in that they are designed to relieve the emotional and physical stresses of both the SCI veteran and his spouse or "significant other" who provide the needed care. The program we advocate would provide carefully trained people to go into the home, to allow the "significant other" the opportunity to take care of business, the shopping, errands, or simply time for themselves, relieving them temporarily from the burden of providing long term care. Respite care is also necessary when the "significant other," be it a spouse or family member, suffers a personal injury or illness.

A respite care program will offer health care in the home environment in lieu of an institutional setting. Realizing the ever-increasing cost associated with care provided in a hospital or in a nursing home, respite care can prove to be very cost effective. For example, the cost of providing three hours of care daily, by a licensed practitioner in the home, is considerably less than the cost of three hours of any service provided by a hospital or nursing home, if such services were available.

Implementation of respite care programs are growing nationwide. They are supported in various ways through federal and state funding, and by some private insurance. For example, in the State of New York respite care programs are being conducted for the elderly through senior citizen programs, and, the State of Washington is presently conducting five different respite care pilot projects with resultant reports forthcoming.

The requirement for the VA Administrator to report to Congress on respite care is a needed and overdue action. Hopefully, the report of the Administrator will address the need for respite care to help alleviate the psychological burdens placed on family members. Often the day-to-day care provided by a family member is overlooked even though it is essential in precluding a veteran's institutionalization. The respite care program in combination with and/or extension of VA Hospital Based Home Care, outpatient and other VA programs can only serve the government in a cost-effective manner by reducing the need of institutional care for veterans needing long-term care.

As we stated in similar testimony before the House Committee on Veterans' Affairs on June 13, 1984, the Veterans Administration is in the unique position to incorporate into its program on aging an inclusive investigative research profile on the psychological, medical, sociological, and economic needs of aging spinal cord injured veterans. Additionally, we believe that passage of Section 9 would enhance such studies by including the needs of the aging SCI veteran. We believe that positive approaches to noninstitutional care such as respite care programs will demonstrate the need to provide differing health care extension programs for all veterans.

PVA is supportive of S. 6, but would strongly advise and urge the Chairman that implementation of the "Respite Care" program should include younger as well as the "older catastrophically disabled" service and nonservice-connected veterans.

In providing respite care we are aware that such a program will have different meanings for the different needs of different people. However, to repeat, the overall concept and need of a respite care program is what is important and one that we support, if amended appropriately to include both service-connected and nonservice-connected severely disabled veterans.

Finally, the U.S. News and World Report dated October 22, 1984, Editor's Page, 78, Mr. Marvin Stone reported, "the long-run importance of continuing the live-at-home efforts is underlined by finding that a person can be maintained at home for $4,000 to $6,000 a year, whereas a nursing home costs $15,000 to $35,000. This and other programs for the elderly, chronically ill and castrophically disabled (emphasis added) are examples of where a little federal money and planning could save a lot later." PVA is in agreement, and again we anticipate the passage of this necessary and visionary legislation.

PVA also supports S. 6, Section 9(B), which would provide an increase in the involvement of the VA's Geriatric Research, Education, and Clinical Centers (GRECC's). The importance of this worthwhile program to study the needs of aging veterans is clearly recognizable. Again, PVA believes this program, established by Congress in Public Law 96-330, should require the Veterans Administration to become involved in, and that the research study should include, the needs of the aging spinal cord injured veteran.

Referring specifically to Section 9(a)(i)(B)(2) as this section applies to and where it says, "the Administrator shall accord a priority to those veterans with service-connected disabilities." PVA agrees and advocates that service connected veterans receive priority when selecting participants in the program. However, as a matter of clarification, PVA also believes that the bill should not infer or exclude entirely those nonservice-connected veterans with similar needs.

Section 9.(A), the appointment of a VA employee to serve as the case manager to coordinate the provisions of health services of an agency other than the VA to veterans is imperative. We favor this consideration, because it is responsible to do so, and secondly, it assures control and extending of the VA programs, while monitoring the outside services received by the veterans.

Section9.(3)(B) - PVA anticipates that the pilot program for noninstitutional treatment programs, if enacted, would require an even closer, cooperative relationship with the VA, between other agencies and the veteran, as the Administrator may provide in-kind assistance through the services of VA employees, and sharing resources with other entities furnishing services to veterans; the importance and the need of a case manager is as previously mentioned, reinforced. PVA believes this program is cost-effective, and, because it is, the VA may find within its current budget the ability to establish the program.

Section 10 (a)(i) - PVA is in favor of this section, but only to evaluate the question to report on federal government responsibility to individuals who served with voluntary civilian organizations in Vietnam. This effort is humanitarian in approach, but we believe premature. Right now, PVA's primary concern is for meeting the unmet needs of veterans who have served in the uniformed services. We do, if this section is implemented, look forward to the report with interest and what the final deliberations may be.

S. 875

Mr. Chairman, PVA, with certain strong reservations, favors the provisions of S. 875, "the Vietnam Veterans' Resource Center Act of 1985." Senator Murkowski introduced S. 875, which is to create a pilot program of 10 Vietnam Veterans' Resource Centers. The purpose is to increase the overall effectiveness of services furnished to potentially eligible Vietnam veterans by increasing the coordination of the provisions of the services to the potentially eligible veterans and by the establishment of the pilot programs within 10 of the present readjustment counseling centers. This measure truly recognizes the successful achievements of the VA's 153 Readjustment Counseling Centers, often identified as the Vietnam Veterans Outreach Program. For many veterans, these centers serve as the "front door" to the services provided by the VA. The hard fought effort to establish this store front grassroots program remains vital in order to provide the needed employment and psychological counseling to veterans. The acceptance of this program, by the veteran in need, will now allow him to cope more readily with receipt of professional counseling under one roof, where at one time this may have been impossible. This effort reinforces our concerns to eventually move the outreach program into the VAMC's.

However, until this can be accomplished and as one can understand, there remains some resistance as the veteran is fearful to be out of his environment, and traveling to other facilities to receive necessary services in what the veteran considers as bureaucratic surroundings of the VAMC and VA Regional Office, which is inconceivable to him. Providing a compliment of logistical support locally will enhance the efforts of the VA to restore the veterans' confidence toward his own goals of self-esteem, good health, and eventual employment, and when accomplished will contribute to the cost-effectiveness and the goals of the program.

PVA absolutely opposes any efforts for a team of medical practitioners to provide medical services at the Resource Centers. Those kinds of medical services that may be necessary must continue to be provided within the confines of VA Medical Centers and/or VA outpatient clinics, or military medical facilities, if and as authorized.

PVA also strongly opposes S.1915(a)(b) and (c) whereas "the Deputy Administrator of Veterans' Affairs shall administer the pilot program required by Section 1913 of this title. PVA adamantly believes this responsibility should remain within the authority of the Chief Medical Director of DM&S and where the Director of the Department of Veterans' Benefits will work in consultation and advise the CMD. PVA would only support this legislative initiative based on clarification and redefinition of our concerns for authority and the noninvolvement of medical practitioners, excluding psychiatric counselors and/or social workers.

In addition with the proposed losses and freeze of FTEE positions within the VA system, duplication of medical services by the VA at the Resource Centers is precluded, if not impossible to provide. This consideration must be taken into account by the Committee and with respect for PVA's concerns.

Mr. Chairman, thank you for your understanding by introducing this legislation.

S. 876

PVA favorably supports and appreciates the efforts of Chairman Murkowski to introduce and include in S. 876 the "Veterans' Administration Health Care Programs Improvement Act of 1985," S. 876, which will provide oversight of the effectiveness of the drug and alcohol program as it pertains to comparing contracting services and programs with or in conjunction with VA programs. We look forward with anticipation to the resultant annual report of the VA, addressing the needs of alcohol and drug abuse treatment programs.

Section 6.(e) Subchapter II of Chapter 3 by adding S.223 provides that the Administrator will establish an Advisory Committee on Veterans' Administration Facility planning. PVA is wholeheartedly in favor of this section. PVA will look forward to the formation of this committee, which is needed. Meanwhile, Mr. Chairman, please be aware of our concerns, which we have conveyed to the Administrator.

While the VA's current management practice used to identify medical facilities needs, Medical District Initiated Planning Process (MEDIPP), assists in formulating construction plans at the district level, PVA finds that the Spinal Cord Injury (SCI) service, which is of the utmost importance to PVA, being a rather unique service within the VA, presently does not fit into this planning process. Meanwhile, we are pleased to be working with the VA Central Office to overcome this shortcoming by providing data on potential sites for needed SCI Centers, and, in a letter dated March 8, 1985, to VA Administrator Walters we again provided our position and comment on the desirability of certain locations for new SCI Centers. Hopefully, the Advisory Committee will enhance the need for a viable VA construction plan.

One concern we wish to express with regard in the current MEDIPP procedure is the lack of a yearly carry-over of approved construction projects. In addition, we are finding that some medical districts are planning to include SCI Centers into their overall construction plan, but there appears to be poor coordination between medical planning districts as to the needs of SCI veterans. The problem then becomes, who within the VA speaks to the needs of the spinal cord injured veteran. Hopefully, this situation will be rectified by this legislative proposal, while PVA continues to monitor these needs, and we continue to investigate potential new sites for SCI Centers.

The VA has prepared two comprehensive studies of SCI veterans and an analysis of the demands they will make on the VA health care system. These studies are entitled, "The Spinal Cord Injury Program Plan: FY 1980--1987" and "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1984--1990." The first noted study is a broad analysis of the VA's SCI program (to include staffing needs, medical specialties required, and other appropriate health care matters), and at the very core of the study is the assumption that VA SCI Centers will be placed where needed in order to better serve SCI veterans.

In this regard we request the VA to continue to take the following factors into consideration when selecting the site for an SCI Center: 1) availability of a suitable existing structure readily accessible in terms of geographical and transportational facilities; 2) strong affiliation with a medical school; and 3) proficiency of medical staff in the disciplines critical to spinal cord injury care and research.

S.1007

Mr. Chairman, PVA appreciates the concern and interest of Senator Rudolph E. Boschwitz and Senator Jeremiah A. Denton for introduction of S. 1007, the "Health Care Promotion Act of 1985." Overall PVA is supportive of this measure, which directs the Administrator to carry out a pilot program to determine the most cost-effective methods of acquiring medical facilities to meet the needs of the Veterans Administration and otherwise to promote additional health care for eligible veterans, and for other purposes. However, we do believe that Section 2, Section 5002, (d)(A), as it pertains to the cost of adapting a facility, should not exceed, versus the cost of new construction. The cost of adapting a facility should be far less than the cost of new construction; otherwise, the purposes intended would be defeated. We suggest that the legislation should reflect that the costs of adapting facilities should not exceed 75% of the cost of new construction for a medical medical facility.

Mr. Chairman, thank you for your understanding in introducing this important legislation.

Means Test Proposal

Mr. Chairman, PVA must question the cost savings initiatives contained in the Administration's proposal for implementation of a "means test," which assumes that veteran demand can be reduced and where the establishment of third party reimbursement is anticipated to produce monetary savings. We are skeptical not only of the projected savings but doubt that such programs will mitigate the growing demand being placed on the VA health-care system.

First, PVA does not oppose a "means test" per se. The institution of any "means test," however, must be equitable, being applied to all non service-connected veterans regardless of age and it must address factors other then gross household income. Significant factors such as the totality of a veteran's health-care needs must be considered in making eligibility determinations rather than relying on a single episode determination. Additionally, the factor of geographic differentials in living costs must be incorporated into any "means test". The establishment of criteria for determining what is household income poses a significant problem.

Most important, the use of a preliminary medical evaluation should not be used as the controlling factor in determining a veteran's health-care needs and ability to pay. A complete, comprehensive diagnosis, post-admittance if necessary, and a thorough consideration of future medical requirements must be incorporated into any determination of ability to pay. If an admitted, diagnosed veteran is then deemed to be able to defray costs, a mechanism for recoupment of diagnostic expenses should be considered whether third party reimbursement or not.

Finally, the question of cost effectiveness must be raised. The institution, nationwide, of the proposed means test implies significant administrative costs with no assurances that the VA will realize savings. If the means test were to winnow out certain veterans with the ability to pay, others currently being denied care would only be admitted to the system. While such a result is a positive aspect of the proposed means test, it can in no way be viewed as a means of reducing costs or demands on the system. Additionally, any use of a preliminary evaluation will address only individual episodes of health-care need and fail to consider the veteran's more extensive spectrum of medical requirements.

The proposal to effect cost savings of $65 million during fiscal year 1986 through the establishment of third party reimbursement is specious at best.

Non service-connected veterans utilizing the VA health-care system do so today because they lack the resources to secure private health care. These veterans, for the most part, have no private health-care coverage. In the cases of those veterans who do have private coverage most extant policies contain exclusionary provisions which preclude payment for treatment in federal facilities.

In addition, the administrative mechanism to implement third party reimbursement currently does not exist within the Veterans Administration. The projected savings assumed in the budget would have to be the net result of establishing such a program and its associated costs. Additional FTEE would be required to administer such a program and a billing procedure would have to be created.

Conclusion

Mr. Chairman and Members of the Committee, to repeat, PVA is aware that this is a time of challenge and we are concerned about the American taxpayer and the need to spend government funds as efficiently and as effectively as possible; therefore, our comments to your proposals, collectively, are to assist you to improve veterans programs and at the same time be cost-effective where possible.

We understand you face the adversity of limited resources, but remember, that VA benefits and the programs we discussed here today were earned in adversity. Integrity, honesty and constancy of both individuals and nations, are and always have been, tested in times of adversity, not times of plenty and of ease. The problems confronting us are a challenge to all of us and yet it is esstneital that we pass the test.

Mr. Chairman, and members of the Committee, I again thank you for the privilege of appearing today. I have discussed numerous concerns and hope I have let some insightfulness here today. This concludes my statement, and I will be glad to respond to any questions that I can.

Mr. **Principi.** Mr. Rhoades.

Mr. **Rhoades.** Thank you. I'm here today really to comment on S. 875, which would create Vietnam Veterans' Resource Centers. I want to make three points about the Centers. For a number of years I think it's been recognized by anybody who works in a community the fragmentation of services that you find for veterans.

Very often veterans end up bouncing around town trying to find exactly who has which services. We think that S. 875 consolidates or will at least provisionally consolidate a number of services and will allow the veteran to stop at one place, rather than having to go to a number of places to get those services.

The VA contends that the services are already being delivered, which they probably are, but we think they're being delivered on a catch-as-catch-can basis. We like the case management concept written into the bill. We think it's very important, and we also think it will lead to better coordination among a lot of entities such as DVB, DM&S, the Department of Labor and so forth.

One should remember that the Vet Centers started out as storefront operations because there was a recognition of a real need for them. There is considerable reluctance among many Vietnam vets to go to large institutions, be they hospitals or the regional offices. S. 875 can be seen as an extension of this concept, not only for readjustment counseling, but for other services. The third point I want to make is that one thing that has always bothered me a little bit about the VA and that is how little community penetration it really has.

The Vet Centers were a radical departure for the VA in terms of the VA as a Government agency working in and in the context of a local community. I think this is one of the great values of the Vet Centers, and I think being able to bring services into a community context is probably the most appealing and most important element in S. 875.

In my written statement, of course, I gave a little history of one-step service centers which I hope you'll find useful. We also made a few recommendations. I'd like to go over those just briefly.

Other witnesses have testified that when you wire Government agency services together or services from a number of different agencies, that the use of the term "may" and "should" normally gets translated as "won't", or "will do so at our convenience".

We especially recommend that DVOP participation in this program be mandated, and not be made a matter of discretion, particularly because despite the Federal-State partnership, it's very hard to get State agencies to quite see it your way.

We also think that the VVRC's need to affirmatively build a strong network into the community. That's why we recommend that one of the staff members be designated as a community relations or community services coordinator, to wire together services that may be available from local agencies to provide services such as the emergency shelter, food, money, legal assistance and so forth.

Our third recommendation has to do with communities that already have existing service centers. In site selection, I would advise that some caution be exercised so as not to set up duplicative services in the same community.

As a matter of fact, it might not be a bad idea to try at least one project which strikes a cooperative agreement with one of the service centers.

We also think job counseling should be given high priority. The Administrative Readjustment Advisory Committee recommended that employment counselors be put into the Vet Centers. We want to reiterate that as a recommendation. We also feel that if the centers are to be effective in finding jobs for their clients, one of the ways they can be most effective is for the committee to act favorably upon reauthorization of the Emergency Veterans' Job Training Act.

As the committee probably knows, Senator Pressler, along with the three new Vietnam veteran Senators—Senators Kerry, Gore and Harkin—have introduced last week S. 1033. We recommend that the committee move expeditiously for hearings on this measure.

I think also one needs to take a look at the administrative structure of the centers as provided for in the legislation. I am not entirely sure that the program needs to be moved under the Deputy Administrator. As a matter of fact, the creation of a task force from various elements within the VA, perhaps chaired by the Director of the Readjustment Counseling Service, might be a suitable alternative.

I would say that once the pilot projects have tested out, if there are problems then the committee might want to consider them, but I would leave the administrative structure pretty much as it is with the creation of an advisory task force.

The last point I really want to make is that whatever is going to be involved in setting this up, it's going to take a lot of training, and I do have one cautionary note, and that is I don't think that the centers should be set up such that they dilute the primary mission of the Vet Centers, which is readjustment counseling.

Case management may turn out to require extra staff, or it may not, and I think this is going to have to be carefully examined.

Thank you.

Mr. PRINCIPI. Thank you, Mr. Rhoades.

[The prepared statement of Dennis K. Rhoades, executive director, Vietnam Veterans of America, follows:]

PREPARED STATEMENT OF DENNIS K. RHOADES, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

Mr. Chairman, Vietnam Veterans of America appreciates the opportunity to appear before this Committee today. Although there are a number of legislative items under consideration, we are focusing our remarks upon S. 875, a bill to create Vietnam Veterans Resource Centers (VVRCs) as pilot projects in ten areas. We are pleased that you have introduced this legislation, Mr. Chairman, because it addresses a problem of long standing: the fragmentary nature of veterans services in local communities and within the VA itself. Many Vietnam veterans, particularly those who visit Vet Centers, have multiple service needs. Moreover, in order for psychological readjustment counseling to be effective, economic, substance abuse and rehabilitation problems must also be addressed - problems which are at present outside the purview of the Vet Centers. VVA also believes that VVRCs, if successful will have a major impact on how the VA delivers services to its veteran clients.

Mr. Chairman, the concept of one-stop multiservice centers for Vietnam veterans has a long history. I would like to spend a moment outlining the history of this concept, because I believe it will provide useful guidance to the Committee in structuring the proposed VVRCs. As early as the 1968, both the President and the Congress recognized that there was no single place to which a returning veteran could go to receive all of the counseling and services he or she might require. Accordingly, on January 30, 1968, President Jonnson established US Veterans Assistance Centers (USVACs) in ten major cites. The USVACs had four basic groals:

1. To promote the highest possible educational achievement.

2. To facilitate rapid social and economic readjustment to civilian life.
3. To receive and channel appropriate action on discrimination complaints concerning civil rights.
4. To further the achievement of a high standard of living and a productive, satisfying life.

USVAC activities were directed toward educationally disadvantaged veterans and involved the participation of the Department of Labor's Reemployment Rights personnel, Civil Service Commission employees and State Employment Service staff. That is where the operation broke down. At the very time that the VA was expanding the number of USVACs first to twenty, then to 50, the Office of Reemployment Rights withdrew its employees. The CSC subsequently reduced its staff, and eventually, most Job Service staff were withdrawn. It has been my personal experience that cooperative work on a program between government agencies is shortlived, except when such cooperation is mandated by law, or motivated by increased funding. I urge the Committee to bear this in mind as the legislation is refined.

Along with tepid support from other government agencies, the USVACs had other problems. The USVACs were essentially benefits cafeterias. Services were highly compartmentalized, depending upon informal referrals. As a result, the success of a USVAC depended wholly upon the initiative of its employees. There was no central case-management involved, which made it difficult for the centers to provide anything more than service for simple, routine needs.

While the USVACs were fading, however, independent self-help organizations for Vietnam veterans were in the process of formation. Starting ofter in veterans affairs offices on college campuses, groups of Vietnam veterans put together organizations which specialized in peer counseling (a forerunner of psychological readjustment) employment, education assistance, discharge upgrading and emergency services. Many of these organizations depended primarily on volunteers, private foundations and church grants, and the VA work study program. With the passage of the Comprehensive Employment and Triaining Act, and the VETS program at Health, Education and Welfare, some of these organizations became financially stable and grew.

Under the Carter Administration, two multi service programs were developed. In 1979, the Veterans Outreach and Community Services (VOCS) program, operated chiefly with CETA Title III funding, set up multiservice self-help programs in eleven major cities. The program provided for matching grants to the cities, and national funding could be matched either by local CETA funds or in-kind services. Some government agencies, such as the Job Service and the VA, outstationed employees at these centers. As VOCS completed development in its eleven cities, the Department of Labor started the Targeted Technical Assistance (TTA) program, which provided local CETA programs with technical assistance and matching Title VI discretionary monies, to set up self-help programs in 40 additional cities. TTA, however, was shortlived. In 1981, under President Reagan Title VI was abolished and the funding for the program disappeared. VOCS suffered the same fate as its national matching grants were not renewed.

Both VOCS and TTA had the same problem: although matching grants were provided from the national level, the quality of service varied considerably because of differences in resources provided by local and federal agencies. Some VA regional offices provided veterans benefit counselors, others did not. DVOP staff were outstatianed in some but not all projects. Lacking a legal mandate, consistency of service among projects was lacking.

During 1982, the Vietnam Veterans Leadership Program was formed. Beginning at first as a community analog to the Vietnam Veterans Memorial, VVLP, in obtaining the Job Training Partnership Act monies as its primary funding, began to emphasize employment programs. Some former VOCS and TTA programs became affiliated with the program; in some areas, community programs for Vietnam veterans were begun. Yet VVLP never shed its public relations orientation and often local programs were nothing more than extended public relations efforts.

Mr. Chairman, I have devoted time to this history because I believe it is important to understand the major pitfalls of programs which have preceded VVRC: lack of federal and local agency support, compartmentalization, and overreliance on public relaitons.

VVA believes that any program which treats Post Traumatic Stress Disorder and its associated problems needs to deal with each Vietnam veteran as a whole person rather than merely a "claimant." For this reason, we are pleased to see the legislation is designing the VVRC on a case-management framework, with centralized intake, assignment of a case manager, individualized readjustment or sevice plans, and through followup. The program must avoid cafeteria-style service including blind referrals. Close coordination among outstationed staff is essential.

Mr Chairman, VVA has some specific recommendations, some of which can be incorporated in the actual language of the legislation, while others should be clearly expressed as Congresslional intent:

1. Government agency services and personnel assistance should be clearly mandated. Particularly with regard to the outstationing of DVOP and other personnel outside the VA.
2. We believe that in order to address the needs of the veteran comprehensively, VVRCs need to build a strong network into the community. We recommend, therefore, that one staff member be designated as a Community Services Coordinator, whose responsbility would be to contact State and local agencies to make arrangements for emergency shelter, food, money, as well as other services such as pro bono legal assistance and rehabilitation.
3. VVA recommends that VVRCs should be carefully designed to insure that they do not duplicate services provided in some communities by veterans community services programs such as the Seattle Veterans Assistance Center and the Rochester Veterans Outreach Center. In fact, we would recommend that at least one pilot project be

established which would enter into a cooperative agreement with an existing community veterans program.

4. Job counseling should be given high priority in the centers. Since many veterans are not likely to be job ready we support creation of a new position that of employment counselor. This counselor would be responsible for preparing non-job ready veteran clients for the working world. Once the veteran becomes job-ready, DVOP staff would assume responsibility for placement. This position was a recommendation made over a year ago by the VA's Readjustment Advisory Committee to Administrator Walters.

5. If the Centers are to be effective in finding jobs for their veteran clients, we believe that they must have the proper tools. We urge the Committee, therefore, to move quickly to extend and reauthorize the Emergency Veterans Job Training Act, as the House is now in the process of doing. The program is cost-effective and would be an invaluable aid to the new VVRCs.

6. The administrative structure of the centers needs careful attention. We believe the center directors should be given full functional authority over the program's activities and staff, and that this authority should be made explicit in the law. Cooperative programs very often flounder when outstationed employees must serve two masters. Adequate space also needs to be provided for the expended programs rather than attempting to fit

new staff into space currently occupied by existing personnel.

Finally, comprehensive training is vital to the success of the VVRCs. Center staff should be provided cross training, as well as training in community networking.

Mr. Chairman, VVA believes that your proposal is an exciting one which, if successful might redefine the way in which services to veterans are provided nationwide. We would be pleased to work with the Committee and its staff as well as the VA, to provide technical assistance in the development of the program.

Mr. **Principi**. Thank you, gentlemen. In view of the hour, we'll submit any remaining questions for the record. I certainly do appreciate your patience, and regret the many disruptions as our respective members set about the business of being six places at once every minute of every day.

Thank you very, very much.

[Whereupon, at 12:35, the committee hearing was adjourned.]

[The committee received the following statements and letters for the hearing record:]

PREPARED STATEMENT OF DR. DONALD L. CUSTIS, FORMER CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. Chairman, I appreciate the opportunity to provide this statement for the record concerning my thoughts on issues covered in S. 6, S. 875 and S. 876.

S. 6

While generally in accord with the various portions of this proposed legislation, I do have specific comment on the following:

1. Expansion of the definition of the Vietnam Era is much needed. Rationale as given for the dates proposed is persuasive and deserving of support.
2. I commend the Committee for its concern regarding OMB's insistence upon GS 11 through 15 grade reduction, even though the VA has no disproportionate number of employees at the salary levels involved.

Even though Title 38 employees are now exempt from that order, there are DM&S Title 5 employees critically involved in both direct and indirect patient care. Typically evasive, OMB identifies no FTE sacrifice to achieve this grade reduction -- only a dollar target of unknown origin --i.e. $459 million for FY 85. The Agency's only possible means of compliance this year is the reduction of 450 FTE in DM&S Title 5. Total decrements by OMB in the out years amount to sixty million dollars. This dangerous personnel action can only be viewed as one of the several arbitrary means of effecting OMB's announced intention for "shrinking the system slowly."

3. The Incentive Therapy and Compensated Work Therapy programs are valuable rehabilitation tools. Relief from the I.G. inspired requirement that proceeds be deducted from VA pension income is badly needed if incentive for patient participation is to be mantained.

4. On the matter of public release of medical quality assurance data, I agree that in general aggregate information in this regard should not be kept confidential. HCFA has recently published the regulations covering PRO legislation. They include a provision that statistics, available for disclosure, would identify individual hospitals, but no individual patients nor individual physicians, explicitly or implicitly. I think it advisable that this same disclosure authority be applied to the VA. However, the phrase "implicitly" would apparently cover the circumstances of a one-man hospital department and thereby afford protection to the data involving an individual physician. This should be balanced against the veteran-patient's right to have an

informed opinion about the quality of his or her care. I am not at all confident that striking the balance on the side of physician privacy is the correct result in all cases or circumstances. Perhaps further restrictions on nondisclosure are necessary.

5. Clinical privilege determination for staff physicians and other professions are a legitimate right of the credentialing committee and hospital administration to establish. The proposal, however, that a reduction or removal of clinical privileges be preceded by appropriate notice to the involved employee with a full opportunity to respond is entirely proper. Such actions, even when of minor degree, can seriously impact professional reputation and also invite legal counteraction. Due process proceedings under section 4110 would assure greater protection for all parties involved.

6. Provision for the expansion of long term care noninstitutional programs in the VA are much needed. I particularly commend the authors for a proposed authority for sharing of such resources between VA and community facilities.

S. 875

While the intention of this proposal to provide better service to the Vietnam veteran is undoubtedly sincere, to me it represents a premature effort to fix something which isn't broken.

The need, beyond the expiration date of the current Vet Center law, for specialized entitlement and dedicated programming for the Vietnam veteran cannot yet be defined. Public Law 96-22 has directed the Administrator to evaluate in a timely fashion any remaining unmet need and report to the Congress.

The "totally new concept" of S. 875 presumes that there is current ineffectiveness in the Vet Center program. I doubt that premise. The Vet Centers are not and were not intended to be medical treatment facilities. Referral to medical clinics and hospitals is and should continue to be the modality for medical care delivery where such entitlement exists. Placing VA physicians in Vet Centers and having them report directly to the Deputy Administrator is and should be categorically unacceptable.

S. 876

This proposed legislation addresses three purposes. First, it will give the VA increased opportunity and flexibility to further develop optional noninstitutional forms of health care. Secondly, it gives increased emphasis to the monitoring of quality of care in the VA medical facilities. Third, it mandates an advisory committee on VA medical facility planning.

All are certainly worthy issues, and I would have no particular comment on the second and third portions of the bill.

The development of noninstitutional programs, as covered in the first portion of S. 876, is going to be an absolute necessity if the needs of the aging veteran are to be met. I am concerned, however, that legislative approaches thus far are timid and restrained. The VA has already acquired considerable experience with pilot programs such as described in S. 876. Adult Day Care Centers and Hospital Based Home Care have already been proven more cost effective than nursing home care. The impact of the aging veteran will be well underway by 1990. There is little time left for preparation.

I am disappointed also that this proposal makes no allowance for sharing of long term care facilities between the VA and community authority. I would even hope that Congress might consider providing seed money to encourage the establishment of cooperative and integrated community based services, not unlike that subsidy provided for Area Health Education Centers. Geriatric training efforts could similarly be shared.

The section on residential care is also commendable in that it would provide authority for the VA to assume program costs. Again, however, the pilot nature of the provision seems to ignore the fact that the V.A. has already had extensive experience with the residential care option.

PREPARED STATEMENT OF VERDAINE L. HOLSTEEN, ACSW, FORMER CHIEF, SOCIAL WORK SERVICES, VA MEDICAL CENTER, TOPEKA, KS

Senator Murkowski and members of the Committee, my name is Verd L. Holsteen, I recently retired from the position of Chief, Social Work Services at the VA Medical Center, Topeka Kansas. I served as chief for over 20 years in two VA medical centers plus five years on the social work staff of a third center. I am pleased to have the opportunity to testify on behalf of the National Association of Social Workers (NASW) on S. 6 and the issue of reduction of grade 11-15 positions within the Veterans Administration.

NASW is the largest organization of professional social workers in the world with 100,000 members throughout the United States. A majority of our members work in health and mental health care. Within the VA system approximately 3,500 professionally trained social workers serve with skill and dedication in providing direct service quality care for veterans.

During the past three decades, Congress dramatically increased the medical and extended services to which veterans are entitled, thus requiring more direct services treatment staff, which includes, among other disciplines, capable and fully trained social workers.

The expansion of knowledge in the psycho-social area of human behavior has also required that those disciplines involved in treatment of psychopathology and psycho-social problems be fully knowledgeable when providing care to our veterans. This requires disciplined study at the graduate level as basic preparation for entry into those positions. In the case of social workers we are talking about master degree professionals with two years of study beyond the baccalaureate level at a graduate school accredited by the Council on Social Work Education.

I come to testify before this committee of my concern, and that of the National Association of Social Workers, of the dangers inherent in the Administration's requirement of a reduction of the number of staff in grades GS 11-15. As presently applied to the Veterans Administration, it exempts those in Title 38 (i.e., physicians, nurses, dentists) and causes the total amount of reduction ($8.1 million) to be met in the disciplines classified under Title 5, (i.e., psychologists, pharmacists, social workers, and a number of other "hands on" treatment staff). These employees at the GS 11-15 level constitute only 17.5% of all those staff members classified under Title 5, as noted by Rep. Montgomery in the Federal Record January 24, 1985.

If the goal of the Administration in this grade reduction effort is to reduce the number of mid-level management personnel as suggested by the Private Sector Survey on Cost Control, then to apply this concept to these Title 5 employees in the VA Medical Centers is seriously mis-applied, because they are mostly "hands on" treatment staff providing care to our veterans and their families. Their grade classification develops from completion of graduate level education; plus knowledge and skills as basic requirement for entrance into their profession. In addition, 1-3 years of supervised experience on the job is necessary to reach the journeyman level. Their grades do not come from managing a large number of other employees.

In the Veterans Administration 1983 Annual Report, "America is #1 Thanks to Our Veterans," p. 36, it is reported that social workers provided direct patient treatment services to 1,621,591 cases as an integral part of VA's multidisciplinary health care delivery system. These are direct patient care activities. Comprehensive social services throughout the health care continuum and integration with community agencies and resources resulted in the placement of 234,706 veterans in the full range of community/residential and continued care facilities. These placement activities are composed of direct work with the veteran, his family, and often with guardians, attorneys, and many local resources. The level of knowledge and skill at this juncture of care determines the success or failure of the whole treatment effort. In addition, social workers provide professional program direction of over 400 patient care programs in a wide range of inpatient and outpatient services. Social workers provide the linkage with local and state agencies, including area agency on aging offices for joint planning and delivery of services to veterans. In fact, without the knowledge, wisdom, and skills of social workers in VA Medical Centers the flow of treated patients, ready to move back to the community, would soon be slowed to a mere trickle. To reduce the number of social work staff in these grade levels comprising the majority of social workers in the VA is tantamount to saying we want to decrease the quality and volume of services to veterans.

Allow me to mention some of the dangers of this grade reduction effort as conceived for the Veterans Administration, Department of Medicine and Surgery.

- The need for quality in treatment by knowledgeable, skilled people to handle complicated medical/psycho-social problems quickly and efficiently will not continue to be met. The present more capable staff will look elsewhere for employment.

This is not unrealistic in a profession which is expanding, according to the Labor Department at the rate of 7% per year.

- A survey of approximately 3,500 veterans in a random sample at 25 VA health care facilities used selected psycho-social indicators to identify patients at risk, who, if not treated, are likely to suffer further medical/social disabilities; 43% were at risk in one or more indicators. At age 75 the percent at risk rose to 58%.

When we put this together with the aging number of WWII veterans, the figures become staggering. In 1985, there are over 5,000,000 age 65 and over. By 1995, there will be 9,000,000, many of them in very high age brackets with multiple illnesses and psycho-social disabilities. With diminished numbers of social work staff at the knowledgeable, skilled and experienced level, the medical centers will not be able to accomplish their Congressional mandate. From my experience at the service level, there is no excess of social work staff.

- VA may continue to be able to hire social workers immediately upon graduation from graduate school, but they will stay only 1-3 years to gain initial experience, then will move to other employment to advance. At this moment our personnel offices are alerting new social work hirees, that they may never be graded higher than the entrance grade of GS-9. This is demoralizing to young people beginning their working career; such policies can only result in loss of quality, efficiency, and public respect. No private organization could succeed with such a policy. Indeed, the Congress itself, would find it difficult to carry out its responsibilities if experienced legislators would not run for re-election because of stiffling conditions, and each 2 years brings mostly new members. There is something very unrealistic and unfair in expecting staff to improve service, advance their knowledge and skills, but deny any increase in financial rewards. Particularly so when one realizes that their regular job description requires knowledge about complicated medical/legal/social/psychological issues, and the skill to bring veterans to the highest possible level of personal functioning.

The following should be noted:

- The grade levels of VAMC health care personnel have been established on the basis of the incumbent's professional preparation and the level of patient care services provided. The vast majority of these positions have not been graded on the basis of administrative or supervisory responsibility. Rather, the present standards and grade levels recognize the professional preparation, competence, and skill required to provide the needed services.

- While each health care professional service has established the professional level at which services will be provided to patients, there is provision for hiring of practitioners at an entrance grade who do not possess the full range of experience and demonstrated clinical competence to provide service at a more senior professional level. Such entry level staff are hired with the full expectation and understanding that upon gaining the requisite experience and demonstration of full professional performance they will be promoted to the journeyman level and potentially to the senior practice level and assume responsibility for the full range of professional services provided by their discipline within the assigned program area.

- As providers of direct patient care services, psychologists and social workers constitute major professional providers of mental health and substance abuse services and provide professional staff of the Readjustment Counseling Service. In addition to the primary services of their respective disciplines, as mental health professionals they also provide mental health consultation and services across DM&S' bed services, ambulatory hospital care, and extended care programs.

Hospital Administration literature is continually concerned with bringing down costs. To do so, there is general agreement that the best way is to reduce the length of stay by one day for each patient. My point is that the reduction of one day's stay is clearly the difference between the functioning of a well educated, knowledgeable and skilled social worker and that of a beginning level worker. This is based on my own years of experience in providing social services to veterans and their families at the point of discharge. And remember, any psycho-social, extended care, financial, community adjustment, or family problems immediately involves a social worker in discharge planning. These complicated problems are never ameliorated without many personal interviews and contacts by the social worker, who must muster up all the knowledge, wisdom and skill he/she possesses during the process of discharge and extended care planning.

Reduction in the grade level of senior professional social workers responsible for the provision of patient care services in a VA Medical Center actually constitutes a decision to provide patient care services at a lower level than is currently provided. This is contrary to the best interests of our veterans. It would appear that health care professionals who provide direct services to patients were not and should not be the intended focus of government wide grade de-escalation. Accordingly we recommend that social workers, and other professional disciplines employed to provide services to veterans be excluded from the de-escalation requirement. We support S. 6 and we commend the efforts of this Committee to ensure continued high quality health care for the veterans of this country.

Thank you for the opportunity to present our views.

PREPARED STATEMENT OF THE INTERNATIONAL CHIROPRACTORS ASSOCIATION AND THE AMERICAN CHIROPRACTIC ASSOCIATION

Mr. Chairman and Members of the Committee:

We appreciate the opportunity to present our views in response to the May 7th hearing held by the Senate Veterans Affairs Committee on S. 1052, legislation that would authorize the Veterans Administration to conduct demonstration projects to furnish chiropractic services to eligible veterans and to evaluate the therapeutic benefits and cost-effectiveness of such service.

The American Chiropractic Association and the International Chiropractic Association, which are two national chiropractic organizations representing the chiropractic profession deeply appreciate the strong support this Committee has given legislative initiatives similar to S. 1052 in the past. As you know, this Committee has passed similar legislation on at least three separate occasions.

S. 1052 is a good bill that the two associations support. Our organizations worked very closely with the bill's author, Veteran's Committee Member, Senator Strom Thurmond prior to its introduction

The bill follows the lead of similar legislation passed during the 98th Congress which authorized chiropractic demonstration projects to be implemented by the Department of Defense for the purpose of evaluating the provision of chiropractic care to those in the armed services. The bill mandates five geographically located chiropractic demonstration projects over the next three fiscal years through cooperative agreements with chiropractic colleges.

The role of the colleges is to coordinate or provide the provision of chiropractic services to eligible veterans and perform joint clinical research and data collection with the Veterans Administration, results which are reported back to Congress annually.

S. 1052 gives the chiropractic profession an opportunity to demonstrate the value of chiropractic care for veterans, and if given an adequate opportunity, chiropractic will have a positive effect on the VA's health delivery system. The bill exercises a strong measure of fiscal restraint by capping total chiropractic care expenditures at $2 million with the funds coming from the existing VA budget.

We also note, that the House of Representatives has already taken positive action on similar legislation, HR 2227, jointly sponsored by Veterans' Affairs Subcommittee Chairman Bob Edgar and Veterans' Committee Chairman G.V. "Sonny" Montgomery. HR 2227 has been approved by both the Subcommittee on Hospitals and Health Care and the entire Veterans' Affairs Committee. It is now part of an omnibus veteran's bell, HR 505, which awaits consideration by the entire House of Representatives.

Mr. Chairman, nearly 40 years ago, representatives from the chiropractic profession testified before Congress on this issue. The VA is long overdue in recognizing the need for our services in their health care delivery system.

It is our strong hope that the committee will give favorable consideration to S. 1052.

We appreciate this opportunity to share our views before this Committee.

The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

May 17, 1985

Senator Frank Murkowski, Chairman
Senate Veterans Affairs Committee
SR-414 Russell Senate Office Building
Washington, DC 20510

Dear Senator Murkowski:

In our statement on health care legislation, presented to the committee at its May 7, 1985 hearing, we indicated that the views of The American Legion on S. 1007, the Veterans Health Care Promotion Act, would be supplied to the committee as soon as our National Veterans Affairs and Rehabilitation Commission completed its analysis of the legislation. That analysis having been completed, the enclosed memorandum sets forth the Legion's views on S. 1007.

Though we disagree with the approach taken in the legislation aiming to make VA health facility planning more cost effective, the several issues raised by the measure may yet be appropriate for consideration by the advisory committee contemplated by section 6 of your own bill, S. 876. So that the hearing record will be complete regarding the views of The American Legion, we respectfully request that this letter and accompanying memorandum be placed in the record of the May 7, 1985 hearing.

As always, your attention to the views of The American Legion is appreciated.

Sincerely,

Paul S. Egan, Deputy Director
National Legislative Commission

THE AMERICAN LEGION
1608 K STREET, N.W.
WASHINGTON, D.C. 20006

Memorandum to: PAUL EGAN, Deputy Director
National Legislative Commission

DATE May 15, 1985

SUBJECT: S. 1007 - "Veterans Health Care Promotion Act".

Following careful analysis, and discussion with the Chairman and several members of the National Veterans Affairs and Rehabilitation Commission it has been decided that we cannot support the intent of S. 1007. The reasons for this position are several, and the following is a brief resume of the reasoning.

It is not the responsibility or obligation of the Veterans Administration to purchase existing hospitals from the private sector that are vacant or underutilized as a result of overconstruction based on an enthusiasm for profit-taking.

Attempts at placing a much larger number of veterans in private nursing homes under five-year contracts may also pose problems. The American Legion does not disagree that community nursing homes play an important role in VA's efforts to provide nursing care to veterans. And the Legion believes in and supports stringent oversight of VA construction costs. However, there are certain postulates that must be taken into consideration.

It may well be that the costs of constructing and operating VA nursing home care units are higher than those in the private sector. It must be realized that these government owned and operated facilities have rigorous obligations placed upon them to provide optimum quality care to veteran patients. Ongoing oversight is provided by the Congress, The American Legion and other veterans organizations, and the VA itself through its professional services. Community nursing homes are not subjected to such thorough and constant policing.

Veterans in VA nursing home care units are usually sicker and stay longer than individuals in private sector nursing homes and, therefore, they require more specialized facilities and equipment for their care. Through its nursing home care units, as well as its medical centers, the Veterans Administration attempts to completely meet all of a veteran's medical needs, not merely the acute condition that necessitates admission, which is not the case in community health care facilities. In addition, the VA nursing home patient load has a high percentage of veterans who because of the degree of care they require are frequently not acceptable to community nursing homes, because they are profit making ventures and such cases are unprofitable.

The stated intent of this legislation is to control the costs of the VA medical construction program. We believe in stringent oversight of VA construction costs. However, as has been stated in the past, we feel that efficiency can be accomplished if VA is more precise in its planning of construction projects. Many times there are several changes made in architect/engineering and construction contracts, at the request of VA, for a given project. Modifications to contracts lead to slippage on completion time and result in increased construction costs. We feel that improvements need to be made in this area, and that the initiation of such improvements would reduce the overall costs of medical construction.

John

JOHN F. SOMMER, JR.
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

EXCERPTS FROM AMERICAN LEGION FIELD REPORTS OF 26 VA MEDICAL CENTERS OVER THE LAST 14 MONTHS DEPICTING PROBLEMS ARISING FROM REDUCTIONS IN TITLE 5 AND TITLE 38 G.S. 11-15 PERSONNEL LEVELS

VAMC WEST HAVEN, CONNECTICUT (March 26-30, 1984)

"The second force at work on this medical center's misery index is $82,000 dollars in grade reductions, GS 11-15. According to the Director, there is no question that these forced incentives to control costs will cause the hospital to establish a radical approach to and/or changes in programs. For example, one ward has had to be closed and another, or possibly two wards, will have to be deactivated. The staffs will be consolidated and then reduced through attrition. All the master level social workers are GS-11; when positions become available, social work associates will be hired to replace them. The same will hold true in Psychiatry and Psychology Services. The Director described this reduction in entrance levels as 'position engineering.'

"In FY 85, DRG adjustment and grade reductions (GS-11/15) can be expected to decrease the funding allocation for this facility by over 290,000 dollars."

VAMC DALLAS, TEXAS (March 26-30, 1984)

"Besides absorbing about 25% of the increased costs from the promotions related to the new nurse qualification standards, this Medical Center is slated to absorb $98,000 as part of the reductions of salary grades 11-15. The President's Private Sector Survey on Cost Control examined the grade structure within the Federal agencies. It was determined that there was a large number of middle management employees (grades 11-15). Consequently, OMB and OPM cut a percentage of dollars from each Federal agency's budget (about 2% of the salary dollars from the designated grade ranges) to encourage a reduction of personnel in these grades. By attrition or personnel action, each agency is to take action to 'get lean' in these positions. There is concern within the VA because employees within title 38, such as, physicians, dentists and nurses can be affected by this. VACO personnel indicated that relief would be sought so only classified positions, not those under title 38, are involved. At the medical center there was concern about the budget reduction, its ramifications and the effects on morale, since dollars will probably be recouped by hiring personnel at lower grade levels."

VAMC LONG BEACH, CALIFORNIA (April 9-17, 1984)

"The Center will also face an average grade reduction beginning in FY 1985 which will result in the loss of $115,696 salary funds. This grade reduction is a result of recommendations made in the recent Grace Commission Report. This report, as applied to the VA, may result in the loss of quality hands-on medical practitioners and result in a dimunition of patient care."

VAMC BAY PINES, FLORIDA (May 21-30, 1984)

"The amount of salary funds reduced for FY 1985 because of the OMB/OPM edict of GS/11-15 grade reductions amounted to $90,000. This policy was reported as hurting the recruitment and retention prospects of the medical center."

VAMC DURHAM, NORTH CAROLINA (June 12-18, 1984)

"Although this facility will gain dollars from the diagnosis-related groupings (DRGs) system of resource distribution, the costs of several combining factors, such as, the salary upgrades for medical technicians and nurses, and the lost dollars for reduction within salary grades 11-15, will require this facility to absorb $400,000 in expenditures from the FY 1985 budget. To absorb these costs FTEE will probably be dropped. Thus, the work force will be reduced approximately 15-20 cumulative FTEE over this two year period. One possible impact from this would be the inability to reopen the beds currently out of service during the renovation of the medical intensive care unit (MICU)."

VAMC SALISBURY, NORTH CAROLINA (June 21-27, 1984)

"For Fiscal Year (FY) 1985, $420,646 in expenditures or the equivalent of 16.4 FTEE must be absorbed. This is the result of the combination of several factors such as the half percent pay increase, the additional costs of nurse and technician promotions, and the dollar reduction for salary grades 11-15. This station has taken the position that it is so poorly staffed that it cannot afford a reduction in personnel and still provide a satisfactory and safe level of patient care.

"For FY 1985, the Center must absorb approximately $420,600 in expenditures or the equivalent of 16.4 Full-Time Employee Equivalents (FTEE). Rather than improving an already impoverished staffing level, a further cut into the existing paucity is projected. Top management has decided to reduce the work load rather than jeopardize patient care via a staffing reduction that cannot be absorbed. Before the FY 1985 budget this medical center identified a minimum of fifty-three (53) critical positions (FTEE) as necessary for the satisfactory provision of patient care. It has gained only 15 RN positions in the last five years, while the patient population has grown older and sicker, and requires more intensive nursing care. Now the budget mandates a work load reduction (or an unacceptable further reduction in personnel) when just the opposite is needed. The staffing requirements of this VAMC cannot continually be ignored or neglected. Additional funded FTEE must be allocated."

VAMC SALT LAKE CITY, UTAH (July 23-27, 1984)

"The hospital had $60,000 removed from the FY 1985 budget for GS-11/15 reductions in grade. The Director remarked that this policy will have an adverse impact on recruitment and retention of employees. Furthermore, the hospital does not have the staff positions to reduce. During the past several years a concerted effort has been made to review staff general service ratings. The hospital today cannot afford to reduce essential service personnel's grades. The Director noted that the $60,000 is most likely to affect all other funding accounts, i.e., drugs and supplies."

VAMC LEXINGTON, KENTUCKY (July 30-August 10, 1984)

"The budget for Fiscal Year (FY) 1984 has been tight, but it has been manageable since supplemental dollars were received. For FY 1985 significant dollars are scheduled to be absorbed due to factors beyond the control of the medical center. These factors involve health care costs, increased salary costs, for example, nurse promotions, and dollars lost to the reduction of grades 11-15 ($61,915). The budget cannot be managed unless these dollars are replaced. The decrease in funds is the equivalent of 19.8 FTEE, and there are not enough staff to absorb a reduction of that magnitude. Since the turnover in the psychiatric programs has increased, if necessary, the least destructive impact to absorb the lost dollars would be to close a 50-bed unit, according to top management.

"If there are no supplemental funds for the FY 1985 budget, this VAMC must absorb $478,000 of unmet, unfunded needs. Of this amount the medical center was assessed $61,915 as a reduction of its budget target allowance for the reduction of position grades 11-15. The total amount of dollars to be absorbed is the equivalent of 13.7 Full-Time Employee Equivalent (FTEE). There are not enough staff to absorb a reduction of this magnitude. Consequently, if there is no relief, management has indicated that the best available alternative appears to be a reduction in census by closing fifty psychiatric beds. No action has been initiated since word is awaited regarding the legislation before Congress which would fund these uncovered costs."

VAMC PROVIDENCE, RHODE ISLAND (September 5-11, 1984)

"The GS 11-15 grade reductions cost the Medical Center $40,883 which equals a loss of two Full-Time Equivalent Employees (FTEE).

The Director stated he hates to see this happen and eventually, GS-9's and 11's will be doing the same job."

VAMC FORT HARRISON, MONTANA (September 17-20, 1984)

"While the DRGs will bring in additional funds, the GS 11-15 grade reduction will cause a loss of $12,000. Implementation instructions have not been clear. No employees have been lost yet, but if they are, the ability to hire someone at a lower grade in this area of the United States will be very difficult."

VAMC TOGUS, MAINE (September 12-18, 1984)

"With the GS 11-15 grade reduction, the Office of Management and Budget (OMB) took $50,725 from the FY 1985 budget. This is equivalent to the loss of 2.5 Full-Time Employee Equivalent (FTEE). Overall, staffing was reported as adequate, however, losses such as those incurred by the grade reduction and DRGs will eventually have a grave impact."

VAMC ASHEVILLE, NORTH CAROLINA (September 17-21, 1984)

"For FY 1985 the medical center is scheduled to absorb the significant increased costs of pay raises, promotions, and health benefits, plus the reduction of salary dollars ($34,000) for grades 11-15.

"Upon questioning, the Director commented that the reduction of salary dollars for grades 11-15 will have a detrimental effect. Overall, it will negatively affect the quality of service because it will limit promotions and foster a reduced staff mobility. This will also possibly hurt the VA, in terms of recruiting quality personnel, because the reduction will impact on the salary incentives which can be offered."

VAMC ALBANY, NEW YORK (October 29-November 2, 1984)

"Approximately $50,000 was lost this fiscal year due to the GS 11-15 reduction imposed by the Office of Personnel Management (OPM). Title 5 employees took the brunt of the reduction because title 38 employees have been exempted this year. The detrimental effect this reduction will have on patient care cannot be expressed strongly enough. The restructuring of the position descriptions will effectively eliminate career ladders for title 5 employees. When vacancies occur, it will become more difficult to fill them with quality people. Most importantly, the morale of the title 5 employees will be affected. Without their full support, the team concept used at VAMCs will be of limited value."

VAMC BRONX, NEW YORK (November 5-9, 1984)

"Due to the GS 11-15 grade reduction, $79,746 was taken from the FY 1985 salary budget. The impact of this was that 11 FTE positions have been abolished and it was reported that more cuts will be made. Presently, the duty number of GS 11-15 is 153 and the target number is 145."

VAMC SYRACUSE, NEW YORK (November 5-9, 1984)

"The amount of money received through the DRGs was nearly offset by the $55,259 lost through the GS 11-15 reductions. This OPM mandate is expected to have a detrimental effect on the VAMC's ability to hire quality personnel, especially with the high tax rate in New York State. Pharmacy Service already has a problem retaining staff because the money is not commensurate with the heavy work load. Without a reprieve, it can only become worse."

VAMC EAST ORANGE, NEW JERSEY (December 7-14, 1984)

"Current Fiscal Year (FY) 1985 staffing and funding levels are lower than the hospital work load requires. The facility is projected to be short $1.4 million in operating funds during FY 1985. This figure is a cumulative medical center figure, including the 1985 Diagnostic Related Grouping (DRG) funding loss of $380,000, the GS 11/15 grade reduction funding loss of $80,000, projected pharmacy shortages and all other account shortages. The Center received an additional $480,000 in operating funds from the Medical Region for FY 1985. However, the facility was still faced with an operating deficit of $1 million for the fiscal year. To offset this shortage, 25 Full-Time Employee Equivalent (FTEE) positions were eliminated from the rolls through attrition for a savings of $600,000. The end result is that the facility still projects an operating deficit of close to $500,000 and is 25 FTEE fewer. With the FY 1986 budget projected to include new funding formulas for long-term care and ambulatory care, in addition to acute care, the medical center is not clear on what future funding levels will be."

VAMC JACKSON, MISSISSIPPI (January 28-February 1, 1985)

"The facility's FY 1985 budget was reduced by $30,000 for GS 11/15 grade reductions. All of the hospital's professional positions in these grades have been inventoried for any possible reductions. However, in order to comply with the intent of the grade reduction proposal the facility cannot comply with any grade cutbacks short of instituting hospital wide reductions in force. In essence, the $30,000 funding loss was absorbed within the Center's budget and no grade reductions were made. The Director noted that the grade reduction program would, if carried through, make hard to recruit positions even more difficult, reduce necessary upward mobility incentives, and make the delivery of quality health care more difficult to provide."

VAMC LITTLE ROCK, ARKANSAS (2 Divisions) (January 28-February 8, 1985)

"Nearly $123,000 was lost due to the GS 11-15 reductions. Although title 38 employees were exempt, the monies were not. This facility is programmed to lose 50 FTEE over the next four years to cover for the dollar losses. The positions that will be severely effected by this are pharmacists, psychologists, social workers, and technologists. The loss of any positions will be very damaging to this facility's ability to provide good care. It was reported that some areas are just treading water at this time. According to 1978 criteria, this facility should have received approximately 1,200 FTE with the activation of both new facilities. This was later trimmed to 800 FTE, but all that were actually received were 394 FTE. Approval was received to implement new programs, such as laser surgery, but to do so means swiping funds and FTE from other programs. Also, the gross space nearly doubled with the Little Rock activation, which adds extra time to daily travel routines.

"It is obvious that the employees at this health care facility are dedicated to providing the best possible assistance and care to veterans. This was visible throughout the survey and reinforced by veterans and their families. This care may become jeopardized. Current staffing levels are minimal. Management has maximized their efforts, and does not feel they are in a crisis situation, but the fact remains that some services are in need of additional FTE. The only way this can be accomplished is to weaken one service to enhance another. Relief does not appear to be on the horizon because the future budgets only reflect reductions. The reduction of GS 11-15 positions is expected to liquidate 50 FTE. Most of these are hands-on-care employees. Also, the ability to hire quality personnel will be stifled. The anticipated changes in the retirement system and pay cuts is also expected to damage their ability to recruit and retain quality people. An increase in staffing is needed, not a decrease. A loss of FTE will place a burden on all programs."

VAMC HIGHLAND DRIVE, PITTSBURGH, PENNSYLVANIA (March 18-22, 1985)

"The Medical Center Director reported that the facility will have to reduce approximately 12-13 positions to comply with the OPM grade reduction policy. Overall, the facility had $35,000 withdrawn from its FY 1985 budget due to this policy. The Medical Center has adopted a policy to reduce GS 11/15 positions through attrition before any actual staff reductions are implemented. To date the facility has adopted the strategy of maintaining several vacant positions rather than reduce any staff grades. The Director noted that this policy will have an adverse impact on future hiring if continued. Prospective employees will find that the lack of upward mobility is not sufficient incentive to seek government careers. The pharmacy service, social work and psychology service are pessimistic about the affect this policy will have on any future hiring. Also during the course of the survey the Chaplain Service received notification from VA Central Office that no new hirees can be assigned a grade higher than GS-10."

VAMC UNIVERSITY DRIVE, PITTSBURGH, PENNSYLVANIA (March 25-April 4, 1985)

"The facility had $72,000 withdrawn from its FY 1985 budget due to the OPM GS 11/15 grade reduction policy. The facility absorbed this loss rather than implement any forced reductions. Primarily the Medical Center is more concerned about the affect on future hiring than on the impact of current staff positions. Over a several year period of time the total amount of funds likely to be withdrawn from the facility's operating budget because of the grade deescalation policy will significantly reduce the facility's budget. Therefore the long-term affects of this policy are viewed more seriously than the impact of the first year of implementation.

"The facility's inability to attract quality personnel in the professional services affected by the OPM policy are viewed as a hindrance in providing the best service possible. This fact and the erosion of morale will in the long run be the most serious consequences of the OPM policy."

VAMC MANCHESTER, NEW HAMPSHIRE (March 18-22, 1985)

"Approximately $25,000 was lost from the FY 1985 budget as a result of the GS 11-15 reductions. The Director said they are slated to lose two positions in this category. A vacant social worker's position is being recruited at the entry (GS-9) level. The Chief of Building Management is being recruited at a GS-10 level. This may be a difficult position to fill because the Assistant Chief is also a GS-10."

VAMC PORTLAND, OREGON (March 18-28, 1985)

"A total of 21 positions are scheduled to be lost due to the reduction in positions with grades 11-15. Due to the way the base line for the reduction was determined, the facility reported it was particularly hit hard. A combination of vacant positions and additional programs contributes to the large assigned number.

"The plan for a grade reduction was described as abominable. The original purpose was to reduce management, but in the VA it is obviously having a significant impact on clinical positions. The Director has decided that no permanent full-time employees in grades 11-15 will be hired in an effort to reach the assigned ceiling. This may negatively impact on the quality of recruitment. However, given the uncertainties of the FY 1986 budget and the mandate to be at a certain ceiling, this is a necessary measure.

"There are already some indications of the effects of the grade reduction. The staff of the Veterans Outreach Program are finally eligible for conversion to permanent career status. For some, after years of commitment and contribution, they are eligible for permanent status, but there are no positions available because the hospital faces the task of reducing its grade level ceiling.

"This facility was recently given the funding and staff ceiling for an Adult Day Health Care Program. This will be one of a limited number of funded programs in the country. However, no additional ceiling was given for grades 11-15 which is the grade level of the necessary staff positions. If hospital ceiling is used for this program, it must detract from existing coverage.

"Immediate action is needed to resolve this situation because the hospitals are in the process of making the requisite changes. If relief is received at the end of the year or later, the impact will have already been established."

VAMC BROOKLYN, NEW YORK (2 Division) (March 19-29, 1985)

"In regard to the proposed GS 11/15 reductions, management predicts severe recruitment and retention problems which will have a negative impact on quality and effective health care. The Director commented that the proposal is not only demoralizing, but also suggests the impossible alternative of providing competent direct patient care by replacing para-professionals with highly developed skills, with personnel below a journeyman level. The Director also noted that some areas, such as Pharmacy and Social Work, can not now compete with the salaries and/or benefits being offered by the private sector and that any suggested reduction in grade will only serve to further erode successful and needed programs."

VAMC DENVER, COLORADO (March 25-29, 1985)

"A great loss will be experienced at this facility because of the impact of the GS 11-15 reduction according to the Director. A total of $55,000 was lost from the FY 1985 budget which is equivalent to 2.5 - 3.0 FTEE. Presently, there are 109 employees in the grade level and the reduction target is for 92.0 by September 30, 1985. Per the Regional Director, 22 positions had to be lost, and presently 17 positions must be reduced by the date previously specified. The loss of so many employees is of critical concern to hospital management, especially regarding being able to accomplish the assigned mission of the Medical Center."

VAMC NORTHPORT, NEW YORK (March 25-29, 1985)

"Over $55,000 was deducted from the 1985 targeted allowance for GS 11-15 reductions. Position wise, Pharmacy Service will take the brunt of the reduction's fallout. Currently, the VA cannot compete with the community or the State of New York. When the unit dose was being implemented at the start of FY 1984, 22 additional positions were received. Thirty-five pharmacists had to be hired to fill these positions. During the first year, thirteen pharmacists left for better paying jobs after being trained by the VA. Morale among the staff is deteriorating because promotions from GS-9 to GS-11 after one year are being held up. These same problems are also occurring in other services, such as, social work and psychology. The future stability of these services is being severely undermined."

VAMC ST. LOUIS, MISSOURI (2 Division) (January 18-February 8, 1985)

I. OBSERVATIONS

"At the time of the survey, a hiring freeze was placed on 6 GS 11/15 positions which have occurred through attrition. There are presently 243 of this position caliber assigned to both divisions. Management does not believe it can reach a ceiling of 229 by the required deadline through attrition only. Of the 29 services directly affected by this mandate, only six have 10 or more of these positions and only two of those did not report additional staffing needs. Social Work, Pharmacy and Psychology, which have approximately the highest number of GS 11/15 positions of the six services, reported that any further reductions would have a devasting affect on their ability to perform their assigned missions. However, management commented that reduction in any of the other services could possibly destroy those programs so there is little choice than to focus on the above mentioned six services. The result could be an elimination of, or certainly a reduction in, certain programs within the services."

II. PHARMACY

"In regard to GS 11-15 reductions, the Chief related that the difficulty in recruiting GS 11 pharmacists has been the lack of selling points such as described above and hiring a qualified pharmacist at a GS-9 level would be impossible. A reduction in professional staff would result in a cut back of services and according to the Chief, would destroy the clinical aspect of Unit Dose leaving pharmacy as nothing more than a distribution service. The potential for medication errors would be enormous. It should be noted that the above five vacancies had to be filled with students acting as technicians to keep the workflow going. Both facilities are hard pressed with the main area of concern in outpatient care."

III. SOCIAL WORK SERVICE

"The Chief imparted that if the threat of the GS 11/15 reductions is carried through the quality of care will be decreased and a proven and successful program will be ruined. Social Work Service is one of the several hospital programs that will be hurt by this movement. According to the Chief, those in authority either do not understand or have forgotten that social work is part of the backbone of the veteran's treatment program. They are forgetting

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the large number of outpatients needing assistance. They are forgetting all of the community programs, Prisoners of War, and other special programs overseen by social workers. Most importantly, they are forgetting that psycho-social needs are directly related to the health care needs of these deserving veterans. A reduction in para-professionals will play havoc on declining programs in the private sector. It will be a matter of days or hours before the veteran is returned to the hospital. The recidivism rate will be enormous. The outcome will be yesteryears revolving door policy."

IV. PROFESSIONAL SERVICES

"The COS considers the GS 11/15 reductions to be the 'single most destructive action towards destroying the VA than anything else since its inception'. According to the COS, the clinical staff must have administrative support to provide quality control. Without this support, the COS stated that quality assurance will suffer."

V. CONCLUSIONS

"The reduction in para-professional grades GS 11/15 is having a direct effect on this hospital's ability to perform its mission to say nothing of the devastating affect on staff morale. The result of this action will be a group of technocrats (non-professionals) attempting to provide support to a limited number of professionals. Care to the veterans will be diminished and mediocrity could become the password for direct patient care. Health care needs of the veteran will be eroded. The Chief of Staff is right in saying this act is the single most destructive action towards destroying the Veterans Administration. It could also be added that this action is a move to higher recidivism."

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 9 1985

Mr. Richard L. Fogel
Director, Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Your April 8, 1985 draft report "VA Has Not Fully Implemented Its Health Care Quality Assurance Systems," has been reviewed.

I am enclosing comments which I believe will clarify certain portions of the report.

Thank you for the opportunity to review this report.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

Enclosure

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ENCLOSURE

VETERANS ADMINISTRATION (VA) RESPONSE TO THE APRIL 8, 1985 DRAFT REPORT "VA HAS NOT FULLY IMPLEMENTED ITS HEALTH CARE QUALITY ASSURANCE SYSTEMS"

CHAPTER 3 - VA'S MEDICAL INSPECTOR HAS NOT ADEQUATELY EVALUATED MEDICAL CENTERS' QUALITY ASSURANCE PROGRAMS

Page 29: GAO's discussion of the preparation phase of the Systematic External Review Program (SERP) should be modified. When the team leader prepares for a review, he/she contacts the region, VA Central Office program officials, and the Medical Inspector, and reviews the Central Office administrative file concerning the facility to be reviewed. Pertinent information is provided to team members before arriving at the facility. The report also states that the Standards, Criteria, Evaluative Algorithms and Measuring Instruments (SCEM's) were developed by what is now the Quality Assurance Office with assistance from VA program officials. The SCEM's were actually developed by field service chiefs and Central Office program officials with leadership and guidance from the QA office.

Page 30: The report states that the SERP team briefs medical center management regarding its findings after completing the review. The SERP team leaders brief management on a daily basis throughout the week of the review as an ongoing part of the validation process. In addition to daily briefings, a formal exit conference is held for medical center management after the review is completed.

Pages 30 and 31: The report discusses the revising and rewriting of the report segments by the team leader without consulting the appropriate team members. Because of time constraints during the review process, any editing or revising needed for clarity purposes is done by the team leader. Under no circumstances does the editing process alter the content or the intent of the recommendations.

Page 32: GAO asserts that SERP reviews have not evaluated the overall effectiveness of medical centers' QA programs. GAO bases this on a review of some reports that contained limited comments or no mention of QA activities. The absence of a reference to QA components in SERP reviews does not mean that the effectiveness of the medical center's QA program was not evaluated. QA is an ongoing process in which problems impacting on the quality of patient care are identified and resolved. Using the SCEM's, QA is evaluated at a medical center by each surveyor and by the team leader who comprehensively reviews QA documents provided by the medical center.

The report also states that SERP teams do not assess every continuous monitoring function. The team leader and team members review hospital policy memoranda as well as the minutes, actions, and followup of all continuous monitoring committees.

GAO states that SERP teams do not review patient incident reports to determine if they were properly investigated and if the necessary corrective action was taken. The team leader meets with the Medical Inspector before each trip to determine if there are any problems in the reporting of patient incidents. Team members review patient incident reports for patterns and/or trends at the facility.

The report states that the SERP teams do not assess how the credentialing reviews were conducted or the basis for the delineation of privileges. During the survey, the team leader and surveyors review minutes of the Professional Standards Board and the Clinical Executive Board to assess the privileging and credentialing process. Based on these reviews, board actions and personnel folders are selected for individual review.

Page 33: GAO states that SERP teams do not have a methodology or evaluation criteria to assess the effectiveness of the medical center's QA function. As previously mentioned, QA issues are addressed in the individual SCEM's used by the surveyors. The evaluation criteria are in a developmental stage. However, they are not designed to stand alone, but rather to be used as an adjunct to the individual service reviews which address many of the continuous monitors.

Page 36: The report indicates that there is not sufficient time to conduct the reviews. While it is true that time is limited and that some surveyors have to work long hours, the preliminary work performed by the team leader before the visit is designed in part to help team members focus on problem areas and make better use of their time.

CHAPTER 4 - QUALITY ASSURANCE INVESTIGATIONS CONDUCTED BY MEDICAL CENTERS AND THE MEDICAL INSPECTOR

Page 42: The report states that the VA has an incentive program to encourage employees to report incidents of fraud and waste in general, but has no such program for reporting incidents of poor quality of care. The fact that the Inspector General periodically prepares and publishes information bulletins or publications to educate Agency employees concerning the Complaint Center activities should be recognized. Employees are not only encouraged to report incidents of fraud and waste but are also encouraged to report incidents of poor quality of care precipitated by instances of noncompliance with laws, rules, and regulations, or errors in the delivery of services or benefits. The Complaint Center received 106 employee reports of incidents of poor quality of care during a 2-year period ending March 31, 1985. This indicates that VA employees are not only encouraged to report such matters but are taking advantage of the opportunity.

Because VA regulations mandate that employees report all incidents regarding delivery of poor quality of care, it does not appear appropriate to develop an incentive award program that will reward employees who are only complying with regulations.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

December 3, 1985

HR5-129

The Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
  Affairs
United States Senate

Dear Mr. Chairman:

This is in response to the Committee's request for our analysis of the Veterans Administration's (VA's) comments on our June 27, 1985, report VA Has Not Fully Implemented Its Health Care Quality Assurance Systems (GAO/HRD-85-57). On April 8, 1985, we gave VA the opportunity to comment on the draft, but VA did not respond until July 9, after the report had been issued.

VA offered no comments on chapter 2 of the report, in which we stated that none of the 13 medical centers we visited had fully implemented all of VA's quality assurance mechanisms. VA disagreed with parts of our discussion of its Systematic External Review Program process and its inability to determine the overall effectiveness of medical centers' quality assurance programs. In addition, VA did not believe it necessary to initiate an incentive program for employees to report incidents of poor quality care since existing regulations mandate such reporting. We have evaluated VA's comments and continue to believe that our report fairly reflects the status of VA's quality assurance systems at the time of our review. Adjustments made to the final report during its processing reflected points VA made in two of its comments. These and other comments and our responses are enclosed.

We are continuing to review the quality assurance systems at VA medical centers. Currently, we are evaluating the effectiveness of VA's patient injury control program. As you requested on August 30, 1985, our work includes a review of the investigations VA undertakes as a result of incidents reported through this program.

Sincerely yours,

Richard L. Fogel
Director

Enclosure

ENCLOSURE

EVALUATION OF VA COMMENTS ON THE GAO REPORT: "VA HAS NOT FULLY IMPLEMENTED ITS HEALTH CARE QUALITY ASSURANCE SYSTEMS"

VA COMMENT

GAO's discussion of the preparation phase of the Systematic External Review Program (SERP) should be modified. When the team leader prepares for a review, he/she contacts the region, VA Central Office program officials, and the Medical Inspector, and reviews the Central Office administrative file concerning the facility to be reviewed. Pertinent information is provided to team members before arriving at the facility. The report also states that the Standards, Criteria, Evaluative Algorithms and Measuring Instrument (SCEM's) were developed by what is now the Quality Assurance Office with assistance from VA program officials. The SCEM's were actually developed by field service chiefs and Central Office program officials with leadership and guidance from the QA office.

GAO RESPONSE

The final report was adjusted during processing and addresses this comment. Page 20 of the report discusses the prereview preparation for SERP visits and the development of SCEMs.

VA COMMENT

The report states that the SERP team briefs medical center management regarding its findings after completing the review. The SERP team leaders brief management on a daily basis throughout the week of the review as an ongoing part of the validation process. In addition to daily briefings, a formal exit conference is held for medical center management after the review is completed.

GAO RESPONSE

The final report was adjusted during processing and addresses this comment. Page 21 of the report discusses the briefings that take place as part of the SERP review.

VA COMMENT

The report discusses the revising and rewriting of the report segments by the team leader without consulting the appropriate team members. Because of time constraints during the review process, any editing or revising needed for clarity purposes is done by the team leader. Under no circumstances does the editing process alter the content or the intent of the recommendations.

GAO RESPONSE

We agree with VA's comment except for the last sentence. We do not believe VA can provide such assurance as indicated in that sentence because the team leaders generally do not retain team member summaries after the report is drafted. Therefore, VA cannot compare those summaries with the corresponding sections of the final SERP report to determine if recommendations have changed.

VA COMMENT

GAO asserts that SERP reviews have not evaluated the overall effectiveness of medical centers' QA programs. GAO bases this on a review of some reports that contained limited comments or no mention of QA activities. The absence of a reference to QA components in SERP reviews does not mean that the effectiveness of the medical center's QA program was not evaluated. QA is an ongoing process in which problems impacting on the quality of patient care are identified and resolved. Using the SCEM's QA is evaluated at a medical center by each surveyor and by the team leader who comprehensively reviews QA documents provided by the medical center.

The report also states that SERP teams do not assess every continuous monitoring function. The team leader and team members review hospital policy memoranda as well as the minutes, actions and followup of all continuous monitoring committees.

GAO states that SERP teams do not have a methodology or evaluation criteria to assess the effectiveness of the medical center's QA function. As previously mentioned, QA issues are addressed in the individual SCEM's used by the surveyors. The evaluation criteria are in a developmental stage. However, they are not designed to stand alone, but rather to be used as an adjunct to the individual service reviews which address many of the continuous monitors.

GAO RESPONSE

We did not base our finding that the SERP process does not evaluate the overall effectiveness of a center's internal quality assurance program solely on a review of certain SERP reports. As stated on page 22 of the report, we also analyzed the SERP process and documents from the Medical Inspector and Evaluation Office (MIEO) and spoke with VA officials.

We found no VA guidance or criteria for a team leader to use in determining the effectiveness of a facility's quality assurance program. At the time of our review, neither SCEMs nor similar material had been developed for use in reviewing the five mandatory QA program functions: (1) continuous monitoring, (2) patient injury control, (3) utilization reviews, (4) problem-focused health care evaluations, and (5) credentialing and delineation of clinical privileges. The draft evaluation criteria referred to on pages 22 and 23 of the report have now been finalized and are in use.

During our review, however, the former Deputy Director, MIEO, told us that SERP teams do not review the effectiveness of continuous monitoring functions because they do not have enough time to do so. He added that team leaders have a great deal of work to accomplish in the allotted time and cannot assess effectiveness. The team leaders are limited to reviewing minutes of continuous monitoring committees to see if meetings are held. The former Acting Chief, Health Systems Review Organization Section, MIEO, said that to perform a thorough review of the effectiveness of a facility's continuous monitoring committees might require 6 to 8 weeks.

We do not believe that reviewing the minutes, actions, and follow-up of all continuous monitoring committees is a sufficient evaluation of the committees' efforts to discover and solve all the quality-of-care problems. In our opinion, the SERP team would have to examine a sample of patient care records--such as operation reports, anesthesia records, nurses' worksheets, and progress notes--to be able to identify such problems.

Our review of 17 SERP reports found little or no discussion of required continuous monitoring activities, such as laboratory or mortality and morbidity reviews. For example, two of the facilities we visited had SERP visits shortly after ours. At one facility, mortality or morbidity reviews were not being conducted as required, but the SERP report was silent on the subject. At the other facility, laboratory reviews were not being conducted as required; again, the SERP report was silent on the subject.

VA COMMENT

The report indicates that there is not sufficient time to conduct the reviews. While it is true that time is limited and that some surveyors have to work long hours, the preliminary work performed by the team leader before the visit is designed in part to help team members focus on problem areas and make better use of their time.

GAO RESPONSE

The pre-review preparation is discussed on page 20 of the report. During our review 19 of 33 former team members told us that the time allotted for SERP reviews was insufficient.

VA COMMENT

GAO states that SERP teams do not review patient incident reports to determine if they were properly investigated and if the necessary corrective action was taken. The team leader meets with the Medical Inspector before each trip to determine if there are any problems in the reporting of patient incidents. Team members review patient incident reports for patterns and/or trends at the facility.

GAO RESPONSE

Medical centers are not required to send all patient incident reports to the Medical Inspector. Therefore, the SERP team leader's discussion with the Inspector may not provide an adequate basis for judging the effectiveness of a center's patient injury reporting system. We believe that an assessment of such a system's effectiveness should include a determination of the extent of nonreporting, the sufficiency of investigations of incidents, and implementation of corrective action plans.

VA COMMENT

The report states that the SERP teams do not assess how the credentialing reviews were conducted or the basis for the delineation of privileges. During the survey, the team leader and surveyors review minutes of the Professional Standards Board and the Clinical Executive Board to assess the privileging and credentialing process. Based on these reviews, board actions and personnel folders are selected for individual review.

GAO RESPONSE

The Deputy Associate Director, MIEO (who was responsible for SERPs at the time of our review), said that team leaders and team members reviewed a sample of a facility's staff files to determine if privileges had been delineated and were current but did not assess how the credentialing committee verified credentials or determined what privileges to grant. A SERP team leader confirmed that statement.

VA COMMENT

> The report states that the VA has an incentive program to encourage employees to report incidents of fraud and waste in general, but has no such program for reporting incidents of poor quality of care. The fact that the Inspector General periodically prepares and publishes information bulletins or publications to educate Agency employees concerning the Complaint Center activities should be recognized. Employees are not only encouraged to report incidents of fraud and waste but are also encouraged to report incidents of poor quality of care precipitated by instances of noncompliance with laws, rules, and regulation, or errors in the delivery of services or benefits. The Complaint Center received 106 employee reports of incidents of poor quality of care during a 2-year period ending March 31, 1985. This indicates that VA employees are not only encouraged to report such matters but are taking advantage of the opportunity.
>
> Because VA regulations mandate that employees report all incidents regarding delivery of poor quality of care, it does not appear appropriate to develop an incentive award program that will reward employees who are only complying with regulations.

GAO RESPONSE

We did not recommend, nor did we intend to imply, that an incentive award program should be established for reporting incidents of poor quality care. Rather, we stated only that such a program existed for reporting fraud and waste and not for poor quality care. The fact that 106 reports of poor quality care were submitted to the Inspector General's Complaint Center over a 2-year period shows that the Center is being used but does not indicate the extent to which it could be used.

Public Law 99-166
99th Congress

An Act

To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health-care programs, and for other purposes.

Dec. 3, 1985
[H.R. 505]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Veterans' Administration Health-Care Amendments of 1985.
38 USC 101 note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the "Veterans' Administration Health-Care Amendments of 1985".

(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—HEALTH-CARE PROGRAMS

Sec. 101. Alcohol and drug treatment and rehabilitation.
Sec. 102. Special contract-care authority outside the 48 contiguous States.
Sec. 103. Extension of interim health-care eligibility based on exposure to dioxin or other toxic substances in Vietnam or to nuclear radiation.
Sec. 104. Outpatient and ambulatory services following nursing home or domiciliary care.
Sec. 105. Vietnam Veteran Resource Centers pilot program.
Sec. 106. Technical amendment relating to continuing availability of readjustment counseling.
Sec. 107. Counseling for former prisoners of war.
Sec. 108. Transfers for nursing home care.
Sec. 109. Chiropractic services pilot program.

TITLE II—HEALTH-CARE ADMINISTRATION

Sec. 201. Medical quality-assurance records.
Sec. 202. Authority to expand Geriatric Research, Education, and Clinical Centers program.
Sec. 203. Revision of authority for appointment of student nurses and graduate nurses.
Sec. 204. Quality assurance and credentialing.
Sec. 205. Availability of State financial support for approved State home projects.
Sec. 206. Procedures for reduction or revocation of clinical privileges.

TITLE III—VETERANS' ADMINISTRATION MEDICAL FACILITIES

Sec. 301. Clarification of requirement of congressional approval of construction and acquisition projects.
Sec. 302. Operational and construction planning requirement.
Sec. 303. Major facility prospectus requirement.
Sec. 304. Development of medical-facility modular components.
Sec. 305. Feasibility study of and plan for the purchase of a facility for furnishing hospital and nursing home care.

TITLE IV—MISCELLANEOUS PROVISIONS

Sec. 401. Servicemen's Group Life Insurance and Veterans' Group Life Insurance.
Sec. 402. Extension of authority to operate an office in the Republic of the Philippines.
Sec. 403. Veterans' Administration grade reduction.
Sec. 404. Land transfer, Phoenix, Arizona.
Sec. 405. Modification of restrictions on real property, Milwaukee County, Wisconsin.

houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities; and

"(ii) the historical costs for such care and services for the period of time that the program carried out under subsection (a) of this section was a pilot program, taking into account economic inflation.

Report.

"(4) Not later than February 1, 1988, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the program carried out under this section during fiscal years 1984 through 1987. The report shall include—

"(A) a description of the care and services furnished;

"(B) the matters referred to in paragraphs (1), (2), and (3) of this subsection; and

"(C) the Administrator's findings, assessment, and recommendations regarding the program under this section.".

(b) CONFORMING AMENDMENTS.—(1) The heading for such section is amended by striking out the semicolon and the last two words.

(2) The item relating to such section in the table of sections at the beginning of chapter 17 is amended by striking out the semicolon and the last two words.

SEC. 102. SPECIAL CONTRACT-CARE AUTHORITY OUTSIDE THE 48 CONTIGUOUS STATES.

Puerto Rico.
Ante, p. 481.
Alaska.
Hawaii.

(a) REVISION OF SPECIAL CONTRACT CARE AUTHORITY.—Section 601(4)(C)(v) is amended—

(1) by striking out "(except with respect to Alaska and Hawaii) shall expire on October 31, 1985" and inserting in lieu thereof "with respect to the Commonwealth of Puerto Rico shall expire on September 30, 1988"; and

Virgin Islands.

(2) by striking out "and to the Virgin Islands".

Effective date.

(b) PHASE-OUT OF SPECIAL AUTHORITY IN PUERTO RICO.—(1) Effective on October 1, 1988, such section is amended—

(A) by inserting "(other than the Commonwealth of Puerto Rico)" after "in a State"; and

(B) by striking out "contiguous States" the second place it appears and all that follows through "medical services;" and inserting in lieu thereof "contiguous States and the Commonwealth of Puerto Rico;".

Prohibition.
38 USC 601 note.

(2) During fiscal year 1986, the obligations incurred for Puerto Rico contract care may not exceed 85 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(3) During fiscal year 1987, the obligations incurred for Puerto Rico contract care may not exceed 50 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(4) During fiscal year 1988, the obligations incurred for Puerto Rico contract care may not exceed 25 percent of the obligations incurred for such care for fiscal year 1985.

38 USC 601 note.

(5) For the purpose of this subsection, the term "obligations incurred for Puerto Rico contract care" means the total obligations incurred during a fiscal year for medical services for veterans residing in the Commonwealth of Puerto Rico under the Administrator's authority to contract for hospital care or medical services under clause (v) of section 601(4)(C) of title 38, United States Code, in the Commonwealth of Puerto Rico.

SEC. 103. EXTENSION OF INTERIM HEALTH-CARE ELIGIBILITY BASED ON EXPOSURE TO DIOXIN OR OTHER TOXIC SUBSTANCES IN VIETNAM OR TO NUCLEAR RADIATION.

38 USC 610.

Section 610(e)(3) is amended by striking out "after the end of" and all that follows and inserting in lieu thereof "after September 30, 1989.".

SEC. 104. OUTPATIENT AND AMBULATORY SERVICES FOLLOWING NURSING HOME OR DOMICILIARY CARE.

Section 612(f)(1) is amended—

(1) by striking out "where" the first two places it appears and inserting in lieu thereof "if";

(2) by inserting a comma and "nursing home care, or domiciliary care" after "hospital care" the second place it appears;

(3) by striking out "hospital" the fourth place it appears; and

(4) by striking out "in-hospital" and inserting in lieu thereof "such".

SEC. 105. VIETNAM VETERAN RESOURCE CENTERS PILOT PROGRAM.

38 USC 612A.

Section 612A is amended by adding at the end the following new subsection:

"(h)(1) During the period beginning on January 1, 1986, and ending on September 30, 1988, the Administrator shall conduct a pilot program to provide and coordinate the provision of services described in paragraph (2) of this subsection. The pilot program shall be carried out in order to evaluate the effectiveness, feasibility, and desirability of providing veterans eligible for readjustment counseling under this section with additional services through facilities furnishing such counseling.

"(2) The services referred to in paragraph (1) of this subsection are—

"(A) counseling with respect to, and assistance in applying for, all benefits and services under laws administered by the Veterans' Administration for which veterans participating in the pilot program may be eligible;

Employment and unemployment.
38 USC 2003, 2003A.

"(B) employment counseling, training, placement, and related services described in sections 2003 and 2003A of this title or provided under any other law administered by the Secretary of Labor;

Drugs and drug abuse.

"(C) initial intake and referral services with respect to disabilities related to alcohol or drug dependence or abuse and follow-up services for veterans who have received treatment for such disabilities; and

"(D) assistance in coordinating the provision of benefits and services to veterans participating in the pilot program with respect to such veterans' receipt of—

"(i) services provided under the pilot program; and

"(ii) other benefits and services provided under laws administered by the Veterans' Administration, the Secretary of Labor, or any other Federal agency or official.

"(3)(A) In order to carry out the pilot program, the Administrator shall—

"(i) designate as sites for demonstration projects 10 facilities which on the date of the enactment of this section are providing readjustment counseling under this section; and

"(ii) assign such staff and other resources to such facilities as are necessary to enable such facilities to provide the services referred to in subparagraphs (A) and (C) of paragraph (2) of this subsection.

"(B) Facilities designated under subparagraph (A) of this paragraph shall be known as Vietnam Veteran Resource Centers (hereinafter in this subsection referred to as 'Centers').

"(4) The Administrator—

"(A) shall be responsible for coordinating the assignment and use of employees, on full- or part-time bases, as appropriate, in each Center; and

"(B) shall, in carrying out that responsibility, make maximum feasible use of the Veterans' Administration employees who are providing services at each facility on the date it is designated as a Center under this subsection.

"(5) The Secretary of Labor shall provide for the assignment to each Center, on full- or part-time bases, as the Secretary considers appropriate, of disabled veterans' outreach specialists appointed under section 2003A of this title or employees on the staffs of local employment service offices who are assigned to perform services under section 2004 of this title. 38 USC 2003A. 38 USC 2004.

"(6) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the pilot program during its first 15 months of operation. The report shall include— Report.

"(A) the Administrator's assessment of—

"(i) the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) of this subsection and counseling and services furnished under subsections (a) and (b) of this section; and

"(ii) the appropriateness of the use of the personnel assigned to the program;

"(B) a description of any administrative action that the Administrator plans to take generally to increase the coordination of the provision of such services to veterans eligible for readjustment counseling services under this section;

"(C) any recommendation that the Administrator considers appropriate; and

"(D) a comparison of such assessment, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by subsection (g)(2) of this section.

"(7) Not later than January 1, 1989, the Administrator shall submit to such Committees a final report on the pilot program. The report shall include— Report.

"(A) updates of all information provided in the report submitted pursuant to paragraph (6) of this subsection; and

"(B) the Administrator's final assessment of the pilot program based on 33 months of operation.".

SEC. 106. TECHNICAL AMENDMENT RELATING TO CONTINUING AVAILABILITY OF READJUSTMENT COUNSELING.

Section 612A(g)(1)(B) is amended by striking out "who requested counseling before such date" and inserting in lieu thereof "who request such counseling". 38 USC 612A.

SEC. 107. COUNSELING FOR FORMER PRISONERS OF WAR.

(a) In General.—Subchapter II of chapter 17 is amended by inserting after section 612A the following new section:

38 USC 612B.

"§ 612B. Counseling for former prisoners of war

"The Administrator may establish a program under which, upon the request of a veteran who is a former prisoner of war, the Administrator, within the limits of Veterans' Administration facilities, furnishes counseling to such veteran to assist such veteran in overcoming the psychological effects of the veteran's detention or internment as a prisoner of war.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 612A the following new item:

"612B. Counseling for former prisoners of war.".

SEC. 108. TRANSFERS FOR NURSING HOME CARE.

38 USC 620.

(a) IN GENERAL.—Subsection (a) of section 620 is amended to read as follows:

"(a)(1) Subject to subsection (b) of this section, the Administrator may transfer to a non-Veterans' Administration nursing home, for care at the expense of the United States—

"(A) a veteran—

"(i) who has been furnished hospital care, nursing home care, or domiciliary care by the Administrator in a facility under the direct jurisdiction of the Administrator; and

"(ii) who the Administrator determines—

"(I) requires a protracted period of nursing home care which can be furnished in the non-Veterans' Administration nursing home; and

"(II) in the case of a veteran who has been furnished hospital care in a facility under the direct jurisdiction of the Administrator, has received maximum benefits from such care; and

"(B) a member of the Armed Forces—

"(i) who has been furnished care in a hospital of the Armed Forces;

"(ii) who the Secretary concerned determines has received maximum benefits from such care but requires a protracted period of nursing home care; and

"(iii) who upon discharge from the Armed Forces will become a veteran.

"(2) The Administrator may transfer a person to a nursing home under this subsection only if the Administrator determines that the cost to the United States of the care of such person in the nursing home will not exceed—

"(A) the amount equal to 45 percent of the cost of care furnished by the Veterans' Administration in a general hospital under the direct jurisdiction of the Administrator (as such cost may be determined annually by the Administrator); or

"(B) the amount equal to 50 percent of such cost, if such higher amount is determined to be necessary by the Administrator (upon the recommendation of the Chief Medical Director) to provide adequate care.

Prohibition.

"(3) Nursing home care may not be furnished under this subsection at the expense of the United States for more than six months in the aggregate in connection with any one transfer except—

"(A) in the case of a veteran—

38 USC 612B.

"§ 612B. Counseling for former prisoners of war

"The Administrator may establish a program under which, upon the request of a veteran who is a former prisoner of war, the Administrator, within the limits of Veterans' Administration facilities, furnishes counseling to such veteran to assist such veteran in overcoming the psychological effects of the veteran's detention or internment as a prisoner of war.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 612A the following new item:

"612B. Counseling for former prisoners of war.".

SEC. 108. TRANSFERS FOR NURSING HOME CARE.

38 USC 620.

(a) IN GENERAL.—Subsection (a) of section 620 is amended to read as follows:

"(a)(1) Subject to subsection (b) of this section, the Administrator may transfer to a non-Veterans' Administration nursing home, for care at the expense of the United States—

"(A) a veteran—

"(i) who has been furnished hospital care, nursing home care, or domiciliary care by the Administrator in a facility under the direct jurisdiction of the Administrator; and

"(ii) who the Administrator determines—

"(I) requires a protracted period of nursing home care which can be furnished in the non-Veterans' Administration nursing home; and

"(II) in the case of a veteran who has been furnished hospital care in a facility under the direct jurisdiction of the Administrator, has received maximum benefits from such care; and

"(B) a member of the Armed Forces—

"(i) who has been furnished care in a hospital of the Armed Forces;

"(ii) who the Secretary concerned determines has received maximum benefits from such care but requires a protracted period of nursing home care; and

"(iii) who upon discharge from the Armed Forces will become a veteran.

"(2) The Administrator may transfer a person to a nursing home under this subsection only if the Administrator determines that the cost to the United States of the care of such person in the nursing home will not exceed—

"(A) the amount equal to 45 percent of the cost of care furnished by the Veterans' Administration in a general hospital under the direct jurisdiction of the Administrator (as such cost may be determined annually by the Administrator); or

"(B) the amount equal to 50 percent of such cost, if such higher amount is determined to be necessary by the Administrator (upon the recommendation of the Chief Medical Director) to provide adequate care.

Prohibition.

"(3) Nursing home care may not be furnished under this subsection at the expense of the United States for more than six months in the aggregate in connection with any one transfer except—

"(A) in the case of a veteran—

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"(i) who is transferred to a non-Veterans' Administration nursing home from a hospital under the direct jurisdiction of the Administrator; and

"(ii) whose hospitalization was primarily for a service-connected disability;

"(B) in a case in which the nursing home care is required for a service-connected disability; or

"(C) in a case in which, in the judgment of the Administrator, a longer period of nursing home care is warranted.

Alaska.
Hawaii.

"(4) A veteran who is furnished care by the Administrator in a hospital or domiciliary facility in Alaska or Hawaii may be furnished nursing home care at the expense of the United States under this subsection even if such hospital or domiciliary facility is not under the direct jurisdiction of the Administrator.".

(b) ADMISSION TO CONTRACT NURSING HOMES OF CERTAIN VETERANS.—Subsection (d) of such section is amended—

(1) by inserting "(1)" after "(d)";

(2) by striking out "to any public or private institution not under the jurisdiction of the Administrator which furnishes nursing home care" in the first sentence and inserting in lieu thereof "to any non-Veterans' Administration nursing home";

(3) by inserting after the first sentence the following new sentence: "The Administrator may also authorize a direct admission to such a nursing home for nursing home care for any veteran who has been discharged from a hospital under the direct jurisdiction of the Administrator and who is currently receiving medical services as part of home health services from the Veterans' Administration.";

(4) by striking out the sentence beginning "Such admission" and inserting in lieu thereof the following:

Physicians.

"(2) Direct admission authorized by paragraph (1) of this subsection may be authorized upon determination of need therefor—

"(A) by a physician employed by the Veterans' Administration; or

"(B) in areas where no such physician is available, by a physician carrying out such function under contract or fee arrangement,

based on an examination by such physician."; and

(5) by designating the last sentence as paragraph (3).

(c) DEFINITION OF NON-VETERANS' ADMINISTRATION NURSING HOME.—Subsection (e) of such section is amended—

(1) by inserting "(1)" after "(e)";

(2) by striking out "subsection (a)(ii)" in the second sentence and inserting in lieu thereof "subsection (a)(2)(B)"; and

(3) by adding at the end the following:

"(2) For the purposes of this section, the term 'non-Veterans' Administration nursing home' means a public or private institution not under the direct jurisdiction of the Administrator which furnishes nursing home care.".

38 USC 3203 note.
98 Stat. 43.

(d) IMPROVEMENT IN PENSION PROGRAM ADMINISTRATION.—(1) In order to improve the timeliness of adjustments made pursuant to section 3203(a) of title 38, United States Code, in the amount of pension being paid to a veteran who is being furnished nursing home care by the Veterans' Administration, the Chief Medical Director of the Veterans' Administration shall develop improved procedures for notifying the Chief Benefits Director of the Veterans' Administration when a veteran is admitted to a nursing home.

Report.

(2) The Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the development and implementation of such procedures. The report shall be submitted not later than 90 days after the date of the enactment of this Act.

38 USC 610 note.

SEC. 109. CHIROPRACTIC SERVICES PILOT PROGRAM.

38 USC 601 *et seq.*

(a) ESTABLISHMENT OF PILOT PROGRAM.—(1) The Administrator of Veterans' Affairs shall conduct a pilot program to evaluate the therapeutic benefits and the cost-effectiveness of furnishing certain chiropractic services to veterans eligible for medical services under chapter 17 of title 38, United States Code. Such a veteran is eligible to receive chiropractic services under the pilot program if the veteran was furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine within the 12-month period immediately preceding the commencement of the furnishing of such chiropractic services.

(2) The pilot program shall consist of not less than one demonstration project in each of five geographic regions of the United States designated by the Administrator for the purpose of this section.

(3) The pilot program shall be carried out during the period beginning on January 1, 1986, and ending on December 31, 1988.

98 Stat. 2543.

(b) CONSULTATION AND COORDINATION.—In developing the pilot program, the Administrator shall consult with the Secretary of Defense regarding the demonstration projects carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note). In designing, conducting, and evaluating the pilot program, the Administrator shall obtain advice and recommendations from recognized medical or scientific authorities in the treatment of neuromusculoskeletal conditions of the spine. The Administrator shall ensure that there is adequate participation by chiropractors in the design and evaluation of the demonstration projects, including participation by representatives from chiropractic colleges recognized by an approved accrediting organization.

(c) PAYMENT FOR CHIROPRACTIC SERVICES UNDER THE PILOT PROGRAM.—(1)(A) The Administrator shall pay the reasonable charge for chiropractic services furnished to eligible veterans under the pilot program.

Insurance.
Contracts.

(B) The Administrator may not pay for such services to the extent that the veteran is entitled to such services (or reimbursement for the expenses of such services) under—

(i) an insurance policy or contract;

(ii) a medical or hospital service agreement or membership or subscription contract; or

(iii) a similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

(2) The Administrator—

(A) shall reimburse the veteran for such reasonable charges if the veteran has paid for such services; or

(B) in lieu of reimbursing a veteran for a charge for chiropractic services under subparagraph (A), may pay the reasonable charge for such chiropractic services directly to the chiropractor who furnished the services.

(3) The amount paid for chiropractic services under this subsection may not exceed the amount for such services prescribed under the schedule of reasonable charges established under subsection (d).

(4) Chiropractic services may be provided in private facilities or chiropractic colleges approved in guidelines issued by the Administrator.

Schools and colleges.

(5) Reimbursement of veterans and payments to chiropractors under this subsection shall be carried out under regulations which the Administrator shall prescribe.

Regulations.

(d) Schedule of Reasonable Charges.—The Administrator shall establish a schedule of reasonable charges for chiropractic services furnished under the pilot program. Such schedule shall—

(1) be consistent with the reasonable charges allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u); and

(2) be established in consultation with—

(A) appropriate public and nonprofit private organizations; and

(B) other Federal departments and agencies that provide reimbursement for chiropractic services.

(e) Program Cap.—The amount spent in any calendar year for chiropractic services under the pilot program may not exceed $2,000,000.

Prohibition.

(f) Report.—Not later than April 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation, operation, and results of the pilot program. The report shall include—

(1) the number of requests made by eligible veterans for reimbursement or payment for chiropractic services under this section and the number of such veterans who made such requests;

(2) the number of such reimbursements and payments made and the number of veterans to (or for whom) such reimbursements and payments were made; and

(3) the total amount spent for such reimbursements and payments.

(g) Definitions.—For the purposes of this section:

(1) The term "chiropractic services" means the manual manipulation of the spine performed by a chiropractor to correct a subluxation of the spine. Such term does not include physical examinations, laboratory tests, radiologic services, and any other tests or services determined by the Administrator to be excluded.

(2) The term "chiropractor" means an individual who is licensed as such by the State in which the individual performs chiropractic services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5)).

TITLE II—HEALTH-CARE ADMINISTRATION

SEC. 201. MEDICAL QUALITY-ASSURANCE RECORDS.

Section 3305 is amended—

(1) by inserting "(other than reports submitted pursuant to section 4152(b) of this title)" in subsection (a) after "program"; and

38 USC 3305.

(2) by adding at the end of subsection (b) the following new paragraph:

"(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Veterans' Administration health-care programs (including such information as aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities) that does not implicitly or explicitly identify individual Veterans' Administration patients or employees or individuals who participated in the conduct of a medical quality-assurance review.".

SEC. 202. AUTHORITY TO EXPAND GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS PROGRAM.

38 USC 4101.

Section 4101(f)(1)(A) is amended by striking out "fifteen" and inserting in lieu thereof "25".

SEC. 203. REVISION OF AUTHORITY FOR APPOINTMENT OF STUDENT NURSES AND GRADUATE NURSES.

Section 4114(a)(3) is amended—

(1) by striking out "one year" in the second sentence of subparagraph (A) and inserting in lieu thereof "two years"; and

(2) by adding at the end the following new subparagraph:

"(C) A student nurse who has a temporary appointment under this paragraph and who is pursuing a full course of nursing in a recognized school of nursing approved by the Administrator may be reappointed for one year. Other personnel whose appointments are limited by this section to one year may not be reappointed under this subsection.".

SEC. 204. QUALITY ASSURANCE AND CREDENTIALING.

(a) IMPROVEMENTS IN PROGRAMS TO EVALUATE AND ASSURE HEALTH-CARE QUALITY.—(1) Chapter 73 is amended by adding at the end the following new subchapter:

"Subchapter V—Quality Assurance

38 USC 4151.

"§ 4151. Quality assurance program

"(a) The Administrator shall—

"(1) establish and conduct a comprehensive program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery (hereinafter in this section referred to as the 'quality-assurance program'); and

"(2) delineate the responsibilities of the Chief Medical Director with respect to the quality-assurance program, including the duties prescribed in this section.

"(b)(1) As part of the quality-assurance program, the Chief M cal Director shall periodically evaluate—

"(A) whether there are significant deviations in mortality morbidity rates for surgical procedures performed by Department of Medicine and Surgery from prevailing nat al mortality and morbidity standards for similar procedures; and

"(B) if there are such deviations, whether they indicate deficiencies in the quality of health care provided by the Department of Medicine and Surgery.

"(2) The evaluation under paragraph (1)(A) of this subsection shall be made using the information compiled under subsection (c)(1) of this section. The evaluation under paragraph (1)(B) of this subsection shall be made taking into account the factors described in subsection (c)(2)(B) of this subsection.

"(3) If, based upon an evaluation under paragraph (1)(A) of this subsection, the Chief Medical Director determines that there is a deviation referred to in that paragraph, the Chief Medical Director shall explain the deviation in the next report submitted under section 4152 of this title.

"(c)(1) The Chief Medical Director shall— *Infra.*

"(A) determine the prevailing national mortality and morbidity standards for each type of surgical procedure performed by the Department of Medicine and Surgery; and

"(B) collect data and other information on mortality and morbidity rates in the Department of Medicine and Surgery for each type of surgical procedure performed by the Department and (with respect to each such procedure) compile the data and other information so collected—

"(i) for each medical facility of the Veterans' Administration, in the case of cardiac surgery, heart transplant, and renal transplant programs; and

"(ii) in the aggregate, for each other type of surgical procedure.

"(2) The Chief Medical Director shall—

"(A) compare the mortality and morbidity rates compiled under paragraph (1)(B) of this subsection with the national mortality and morbidity standards determined under paragraph (1)(A) of this subsection; and

"(B) analyze any deviation between such rates and such standards in terms of—

"(i) the characteristics of the respective patient populations;

"(ii) the level of risk for the procedure involved, based on—

"(I) patient age;

"(II) the type and severity of the disease;

"(III) the effect of any complicating diseases; and

"(IV) the degree of difficulty of the procedure; and

"(iii) any other factor that the Chief Medical Director considers appropriate.

"(d) Based on the information compiled and the comparisons, analyses, evaluations, and explanations made under subsections (b) and (c) of this section, the Chief Medical Director, in each report under section 4152 of this title, shall make such recommendations with respect to quality assurance as the Chief Medical Director considers appropriate.

"(e)(1) The Administrator shall allocate sufficient resources (including sufficient personnel with the necessary skills and qualifications) to enable the Department of Medicine and Surgery to carry out its responsibilities under this section.

"(2) The Inspector General of the Veterans' Administration shall allocate sufficient resources (including sufficient personnel with the necessary skills and qualifications) to enable the Inspector General to monitor the quality-assurance program.

"§ 4152. Quality-assurance reports

38 USC 4152.

"(a)(1) Not later than February 1 of 1987, 1989, and 1991, the Chief Medical Director shall submit to the Administrator a report on the experience through the end of the preceding fiscal year under the quality-assurance program carried out under section 4151 of this title. *Ante*, p. 950.

"(2) Each such report shall include—

"(A) the data and other information compiled and the comparisons, analyses, and evaluations made under subsections (b) and (c) of such section with respect to the period covered by the report; and

"(B) recommendations under subsection (d) of such section.

"(b) Not later than 60 days after receiving each such report, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report, together with any comment concerning the report that the Administrator considers appropriate.

"(c) A report submitted under subsection (b) of this section shall not be considered to be a record or document as described in section 3305(a) of this title.". 38 USC 3305.

(2) The table of sections at the beginning of chapter 73 is amended by adding at the end the following:

"SUBCHAPTER V—QUALITY ASSURANCE

"4151. Quality assurance program.
"4152. Quality-assurance reports.".

(b) REPORT ON CREDENTIALS OF HEALTH-CARE PROFESSIONALS.—(1) The Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing in detail the current efforts and procedures and future plans of the Veterans' Administration for determining and monitoring the credentials of health-care professionals in connection with their furnishing care to veterans under chapter 17 of title 38, United States Code. 38 USC 601 et seq.

(2)(A) The report shall include a description of each current and planned Veterans' Administration policy or procedure regarding, or arrangement for, credentialing information exchanges.

(B) With reference to any such policy, procedure, or arrangement that is planned and has not been implemented at the time the report required by paragraph (1) is submitted, the Administrator shall—

(i) include in the report a timetable for such implementation; and

(ii) report to the committees on progress toward such implementation every three months thereafter until implementation of each such policy, procedure, and arrangement is achieved.

Upon implementation of each such policy, procedure, and arrangement, a final report on such implementation shall be submitted to the Committees.

(3) For the purposes of this subsection, the term "credentialing information exchanges" includes the exchange of relevant information with a license issuing or monitoring entity—

(A) in order to determine, with respect to an individual who is seeking employment with, or who is employed by, the Veterans' Administration as a health-care professional for the furnishing of care to veterans under chapter 17 of title 38, United States Code—

(i) whether the individual has completed medical or other health-care professional education satisfactorily;

(ii) the current and past licensure and clinical privilege status of the individual; or

(iii) the full employment history of the individual; or

(B) in order to provide appropriate information to such an entity about an individual whose employment with the Veterans' Administration as a health-care professional is terminated—

(i) following the completion of a disciplinary action relating to such individual's clinical competence;

(ii) voluntarily after having had such individual's clinical privileges restricted or revoked; or

(iii) voluntarily after serious concerns about such individual's clinical competence have been raised but not resolved.

(4) For the purposes of this subsection, the term "license issuing or monitoring entity" means—

(A) an appropriate State medical or other health-professional licensing body;

(B) the Federation of State Medical Boards;

(C) the American Medical Association; and

(D) any other public or private entity that the Administrator considers appropriate that is involved with the issuance or monitoring of health-care professional licenses.

Report.

(5) The report required by this subsection shall be submitted not later than 90 days after the date of the enactment of this Act.

SEC. 205. AVAILABILITY OF STATE FINANCIAL SUPPORT FOR APPROVED STATE HOME PROJECTS.

98 Stat. 2689.
38 USC 5035.

(a) Deadline for Availability of State Construction Funds.—Subsection (a)(6) of section 5035 is amended by inserting "by July 1 of the fiscal year for which the application is approved" before "and for its maintenance".

(b) Deferral of Certain Applications.—Subsection (b) of such section is amended—

(1) by inserting "(1)" after "(b)";

(2) by redesignating clauses (1) through (4) as clauses (A) through (D), respectively; and

(3) by adding at the end the following new paragraph:

"(2)(A) The Administrator shall defer approval of an application that meets the requirements of this section if the State submitting the application does not, by the July 1 deadline (as defined in subparagraph (C) of this paragraph), demonstrate to the satisfaction of the Administrator that the State has provided adequate financial support for construction of the project.

"(B) In a case in which approval of an application is deferred under subparagraph (A) of this paragraph—

Grants.
Nursing home.

"(i) the Administrator, in accordance with guidelines established by the Administrator, shall select for award of a grant or grants under this section an application or applications for a nursing home project or projects that the Administrator determines—

"(I) to be most in need;

"(II) would, but for the deferral, not have been approved during the fiscal year in which the deferral occurred; and

"(III) have been provided adequate financial support by the State and are otherwise qualified for approval during the fiscal year; and

"(ii) during the next fiscal year, the application with respect to which approval was deferred shall be accorded priority for approval ahead of applications that had not been approved before the first day of such fiscal year.

"(C) For the purposes of this paragraph, the term 'July 1 deadline' means July 1 of the fiscal year in which the State is notified by the Administrator of the availability of funding for a grant for such project.".

SEC. 206. PROCEDURES FOR REDUCTION OR REVOCATION OF CLINICAL PRIVILEGES.

38 USC 4110 note.

(a) GUIDELINES.—Not later than April 1, 1986, the Administrator of Veterans' Affairs shall prescribe uniform guidelines establishing administrative procedures to be followed in any case in which a reduction or revocation of the clinical privileges of any person employed in a position described in paragraph (1) of section 4104 of title 38, United States Code, is proposed on the basis of a deficiency in the employee's performance of professional responsibilities.

(b) REPORT.—Not later than May 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report (containing a copy of such guidelines) on the implementation of this section.

TITLE III—VETERANS' ADMINISTRATION MEDICAL FACILITIES

SEC. 301. CLARIFICATION OF REQUIREMENT OF CONGRESSIONAL APPROVAL OF CONSTRUCTION AND ACQUISITION PROJECTS.

38 USC 5004.

Subsection (a) of section 5004 is amended to read as follows:

"(a)(1) The purpose of this subsection is to enable Congress to ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility.

"(2) After the adoption by the committees during a fiscal year of resolutions with identical texts approving major medical facility projects, it shall not be in order in the House of Representatives or in the Senate to consider a bill, resolution, or amendment making an appropriation for that fiscal year or for the next fiscal year which may be expended for a major medical facility project—

"(A) if the project for which the appropriation is proposed to be made is not approved in those resolutions; or

"(B) in the event that the project is approved in the resolutions, if either—

"(i) the bill, resolution, or amendment making the appropriation does not specify—

"(I) the medical facility project for which the appropriation is proposed to be made; and

"(II) the amount proposed to be appropriated for the project; or

"(ii) the amount proposed to be appropriated for the project (when added to any amount previously appropriated for the project) exceeds the amount approved for the project.

Prohibition.

"(3) No appropriation may be made for the lease of any space for use as a medical facility at an average annual rental of more than $500,000 unless each committee has first adopted a resolution approving such lease and setting forth the estimated cost thereof.

"(4) For the purpose of this subsection, the term 'major medical facility project' means a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $2,000,000. Such term does not include an acquisition by exchange.".

SEC. 302. OPERATIONAL AND CONSTRUCTION PLANNING REQUIREMENT.

(a) Requirement for Improved Planning.—Subsection (a) of section 5007 is amended— 38 USC 5007.

(1) by inserting "(1)" after "(a)";

(2) by striking out "and alteration" the second place it appears in the first sentence and inserting in lieu thereof "alteration, and operation";

(3) by striking out the second and third sentences; and

(4) by adding at the end the following new paragraphs:

"(2) Each such report shall contain— Report.

"(A) a five-year strategic plan for the operation and construction of medical facilities—

"(i) setting forth—

"(I) the mission of each existing or proposed medical facility;

"(II) any planned change in such mission; and

"(III) the operational steps needed to achieve the facility's mission and the dates by which such steps are planned to be completed; and

"(ii) a five-year plan, based on the factors set out in subclause (i) of this clause, for construction, replacement, or alteration projects for each such facility;

"(B) a list, in order of priority, of not less than 10 hospitals that, in the judgment of the Administrator, are most in need of construction or replacement; and Hospitals.

"(C) general plans (including projected costs, site location, and, if appropriate, necessary land acquisition) for each medical facility for which construction, replacement, or alteration is planned under clause (A)(ii) of this paragraph.

"(3) The report under this subsection shall be submitted not later than June 30 of each year.". Report.

(b) Technical Amendments.—Subsection (b) of such section is amended—

(1) by striking out "(beginning in 1981)";

(2) by inserting "(1)" after "medical facility"; and

(3) by striking out "title and, in the case of the second and each succeeding report made under this subsection," and inserting in lieu thereof "title, and (2)".

(c) Clerical Amendments.—(1) The heading for such section is amended to read as follows:

"§ 5007. Operational and construction plans for medical facilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5007. Operational and construction plans for medical facilities.".

SEC. 303. MAJOR FACILITY PROSPECTUS REQUIREMENT.

Section 5004(b)(1) is amended by inserting "and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a description of the consideration that was given to 38 USC 5004.

acquiring an existing facility by lease or purchase" after "such facility".

38 USC 5003 note.

SEC. 304. DEVELOPMENT OF MEDICAL-FACILITY MODULAR COMPONENTS.

In order to evaluate the applicability to the Veterans' Administration of the use of modular components in the design and construction of medical facilities for the furnishing of hospital care and to determine the efficiency and cost-effectiveness of that approach, the Administrator of Veterans' Affairs shall, not later than one year after the date of the enactment of this Act, develop a modular approach to the planning and design of an appropriate Veterans' Administration medical facility for the furnishing of hospital care.

SEC. 305. FEASIBILITY STUDY OF AND PLAN FOR THE PURCHASE OF A FACILITY FOR FURNISHING HOSPITAL AND NURSING HOME CARE.

President of U.S.
Florida.

98 Stat. 2324.

In the documents submitted by the Administrator of Veterans' Affairs to the appropriate committees of the Congress at the time of and in connection with the submission, pursuant to section 1105 of title 31, United States Code, of the Budget for fiscal year 1987, the Administrator shall include the results of a feasibility study which he shall conduct of, and if indicated by such study provide a feasibility plan for, the purchase for Veterans' Administration use of a medical facility that is located in an urban area and is suitable for furnishing both hospital and nursing home care services, and meets the current and projected needs and specifications of the Veterans' Administration for furnishing health care to eligible veterans. In such Budget, the President, as warranted by such feasibility plan, shall include a request for an appropriate amount to purchase such a facility which meets those needs and specifications: *Provided*, That this section shall not be construed to require the Administrator to provide a feasibility plan with respect to the purchase of a facility that would have the effect of making it infeasible to construct, acquire, or lease a medical facility in the Florida panhandle or to expand the Biloxi/Gulfport Veterans' Administration Medical Center to furnish health care to veterans in the area.

TITLE IV—MISCELLANEOUS PROVISIONS

SEC. 401. SERVICEMEN'S GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE.

38 USC 767.

(a) SERVICEMEN'S GROUP LIFE INSURANCE.—(1) Subsection (a) of section 767 is amended—

(A) by striking out "$35,000" and inserting in lieu thereof "$50,000"; and

(B) by striking out "the amount of $30,000, $25,000, $20,000, $15,000, $10,000 or $5,000" and inserting in lieu thereof "an amount less than $50,000 that is evenly divisible by $10,000".

(2) Subsection (c) of such section is amended by striking out "the amount of" the first place it appears and all that follows through "as the case may be," and inserting in lieu thereof "any amount less than $50,000, such member may thereafter be insured under this subchapter in the amount of $50,000 or any lesser amount evenly divisible by $10,000".

(3) Subsection (d) of such section is amended—

(A) by striking out "the effective date of this subsection" each place it appears and inserting in lieu thereof "January 1, 1986"; and

(B) by striking out "up to a maximum of $35,000 (in any amount divisible by $5,000)" and inserting in lieu thereof "in the amount of $50,000 or any lesser amount evenly divisible by $10,000".

(b) VETERANS' GROUP LIFE INSURANCE.—(1) Subsection (a) of section 777 of such title is amended—

38 USC 777.

(A) by striking out the first sentence and inserting in lieu thereof the following: "Veterans' Group Life Insurance shall be issued in the amounts specified in section 767(a) of this title. In the case of any individual, the amount of Veterans' Group Life Insurance may not exceed the amount of Servicemen's Group Life Insurance coverage continued in force after the expiration of the period of duty or travel under section 767(b) or 768(a) of this title."; and

Ante, p. 956.

38 USC 767; 768.

(B) by striking out "$35,000" in the sentence immediately following the matter inserted by clause (A) and both places it appears in the last sentence and inserting in lieu thereof "$50,000".

(2) Such section is further amended by adding at the end the following new subsection:

Individual Ready Reserve.
Inactive National Guard.

"(h)(1) Notwithstanding any other provision of law, members of the Individual Ready Reserve and the Inactive National Guard are eligible to be insured under Veterans' Group Life Insurance. Any such member shall be so insured upon submission of an application in the manner prescribed by the Administrator and the payment of premiums as required under this section.

"(2) Notwithstanding subsection (b)(2) of this section, Veterans' Group Life Insurance coverage under this subsection shall be issued on a renewable five-year term basis, but the person insured must remain a member of the Individual Ready Reserve or Inactive National Guard throughout the period of the insurance in order for the insurance of such person to be renewed.

"(3) For the purpose of this subsection, the terms 'Individual Ready Reserve' and 'Inactive National Guard' shall have the meanings prescribed by the Administrator in consultation with the Secretary of Defense.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on January 1, 1986.

38 USC 767 note.

SEC. 402. EXTENSION OF AUTHORITY TO OPERATE AN OFFICE IN THE REPUBLIC OF THE PHILIPPINES.

Section 230(b) is amended by striking out "October 31, 1985" and inserting in lieu thereof "September 30, 1988".

Ante, p. 481.

SEC. 403. VETERANS' ADMINISTRATION GRADE REDUCTION.

(a) Section 210(b) is amended by adding at the end the following new paragraphs:

38 USC 210.

"(3)(A) The Administrator may not implement a grade reduction described in subparagraph (B) of this paragraph unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing a detailed plan for such reduction and a detailed justification for the plan. Such report shall include a determination by the Administrator (together with data supporting such determination) that, in the

Report.

Effective date.

personnel area concerned, the Veterans' Administration has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to the number of such employees at the salary levels involved who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any grade reduction described in such report may not take effect until the end of a period of 90 calendar days (not including any day on which either House of Congress is not in session) after the report is received by the committees.

"(B) A grade reduction referred to in subparagraph (A) of this paragraph is a systematic reduction, for the purpose of reducing the average salary cost for Veterans' Administration employees described in subparagraph (C) of this paragraph, in the number of such Veterans' Administration employees at a specific grade level.

"(C) The employees referred to in subparagraph (B) of this paragraph are—

"(i) health-care personnel who are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services;

"(ii) individuals who meet the definition of professional employee as set forth in section 7103(a)(15) of title 5; and

"(iii) individuals who are employed as computer specialists.

Report.

"(D) Not later than the forty-fifth day after the Administrator submits a report under subparagraph (A) of this paragraph, the Comptroller General shall submit to such Committees a report on the Administrator's compliance with such subparagraph. The Comptroller General shall include in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination (and of the data supporting such determination) made under such subparagraph.

Prohibition.

"(E) In the case of Veterans' Administration employees not described in subparagraph (C) of paragraph (3), the Administrator may not in any fiscal year implement a systematic reduction for the purpose of reducing the average salary cost for such Veterans' Administration employees that will result in a reduction in the number of such Veterans' Administration employees at any specific grade level at a rate greater than the rate of the reductions systematically being made in the numbers of employees at such grade level in all other agencies and departments of the Federal Government combined.".

Real property.

SEC. 404. LAND TRANSFER, PHOENIX, ARIZONA.

(a) Requirement for Transfer.—The real property described in subsection (b) and the structures on such property on the date of the enactment of this Act shall be transferred without compensation or reimbursement from the control and jurisdiction of the General Services Administration to the control and jurisdiction of the Veterans' Administration.

(b) Description of Land.—The real property referred to in subsection (a) is a tract of land consisting of 3.4 acres, more or less, in Phoenix, Arizona, that—

(1) was formerly part of the Veterans' Administration Medical Center, Phoenix, Arizona; and

(2) was declared to be excess to the needs of the Veterans' Administration in a report to the General Services Administration dated September 25, 1959.

SEC. 405. MODIFICATION OF RESTRICTIONS ON REAL PROPERTY, MILWAUKEE COUNTY, WISCONSIN.

(a) Release of Reversionary Interest.—The Administrator of Veterans' Affairs shall execute such instruments as may be necessary to modify the conditions under which the land described in subsection (b) will revert to the United States in order to permit Milwaukee County, Wisconsin, to lease all or part of such land to a nonprofit corporation which—

(1) shall construct and equip on such land structures, facilities, and other permanent improvements useful for public recreational purposes or general civic purposes; and

(2) shall use such land for such recreational or civic purposes.

(b) Description of Land.—The land referred to in subsection (a) is—

(1) the land conveyed to Milwaukee County, Wisconsin, pursuant to the Act entitled "An Act to authorize the Administrator of Veterans' Affairs to convey lands and to lease certain other land to Milwaukee County, Wisconsin", approved September 1, 1949 (63 Stat. 683); and

(2) the land conveyed to Milwaukee County, Wisconsin, pursuant to the Act entitled "An Act authorizing the Administrator of Veterans' Affairs to convey certain property to Milwaukee County, Wisconsin", approved August 27, 1954 (68 Stat. 866).

(c) General Limitations.—The Administrator may carry out this section subject to such terms and conditions (including reservations of rights for the United States) as the Administrator determines to be necessary to protect the interests of the United States.

SEC. 406. AUTHORITY TO RELEASE LIMITATION ON USE OF REAL PROPERTY, MCKINNEY, TEXAS.

(a) Release of Limitation.—The Administrator of Veterans' Affairs shall execute such instruments as may be necessary to release the limitation to recreational purposes only on the use of the land described in subsection (b).

(b) Description of Land.—The land referred to in subsection (a) is two parcels of land, consisting of a total of 38.741 acres, that were conveyed by the Administrator to the city of McKinney, Texas, by deed of May 5, 1965, under the authority of Public Law 88-438 (78 Stat. 444, approved August 14, 1964).

SEC. 407. MODIFICATION OF RESTRICTIONS ON REAL PROPERTY AND CONVEYANCE OF A FENCE ON SUCH PROPERTY, SALT LAKE CITY, UTAH.

(a) Modification of Restriction.—(1) The Administrator of Veterans' Affairs shall execute such instruments as may be necessary in order to authorize the land conveyed under the authority of the Act referred to in paragraph (3) to be used—

(A) without regard to any limitation required by section 2 of that Act, but

68 Stat. 580.

(B) subject to the limitations set forth in paragraph (2).

(2) Any instrument executed under paragraph (1) shall provide, with respect to the tract of land conveyed under the Act referred to in paragraph (3)—

(A) that such tract may be used only for hospital, educational, civic, residential, or related purposes;

(B) that, if any part of such tract is used in any manner that is determined by the Administrator to interfere with the care and treatment of any patient at a Veterans' Administration health-care facility located in the reservation described in such Act, such use shall cease immediately upon notice by the Administrator of such interference to the person holding legal title to such part at the time such use occurs;

(C) that, if any part of such tract is used for a purpose other than a purpose prescribed in clause (A), title to such part shall revert to the United States; and

(D) that, if any interference referred to in clause (B) does not cease as required under such paragraph, title to the part of such land that is being used in a manner to cause such interference shall revert to the United States.

Any such instrument may contain such additional terms and conditions (including reservations of rights to the United States) as the Administrator determines to be necessary to protect the interests of the United States.

(3) The Act referred to in paragraphs (1) and (2) is the Act entitled "An Act authorizing the Administrator of Veterans' Affairs to convey certain property to the Armory Board, State of Utah", approved July 29, 1954 (68 Stat. 579).

(b) CONVEYANCE OF FENCE.—The Administrator shall convey, without consideration, to the Armory Board of the State of Utah all right, title, and interest of the United States in the fence erected as required by the quitclaim deed issued to the Armory Board by the Administrator on October 14, 1954, under the authority of the Act referred to in subsection (a)(3). The conveyance shall contain such terms and conditions as the Administrator determines to be necessary to protect the interests of the United States.

Approved December 3, 1985.

LEGISLATIVE HISTORY—H.R. 505 (S. 876):

HOUSE REPORT No. 99-114 (Comm. on Veterans' Affairs).
SENATE REPORT No. 99-101 accompanying S. 876 (Comm. on Veterans' Affairs).
CONGRESSIONAL RECORD, Vol. 131 (1985):
    May 21, considered and passed House.
    July 30, considered and passed Senate, amended, in lieu of S. 876.
    Oct. 30, House concurred in Senate amendments with amendment.
    Nov. 6, 13, Senate concurred in House amendment with amendment.
    Nov. 14, House concurred in Senate amendments.